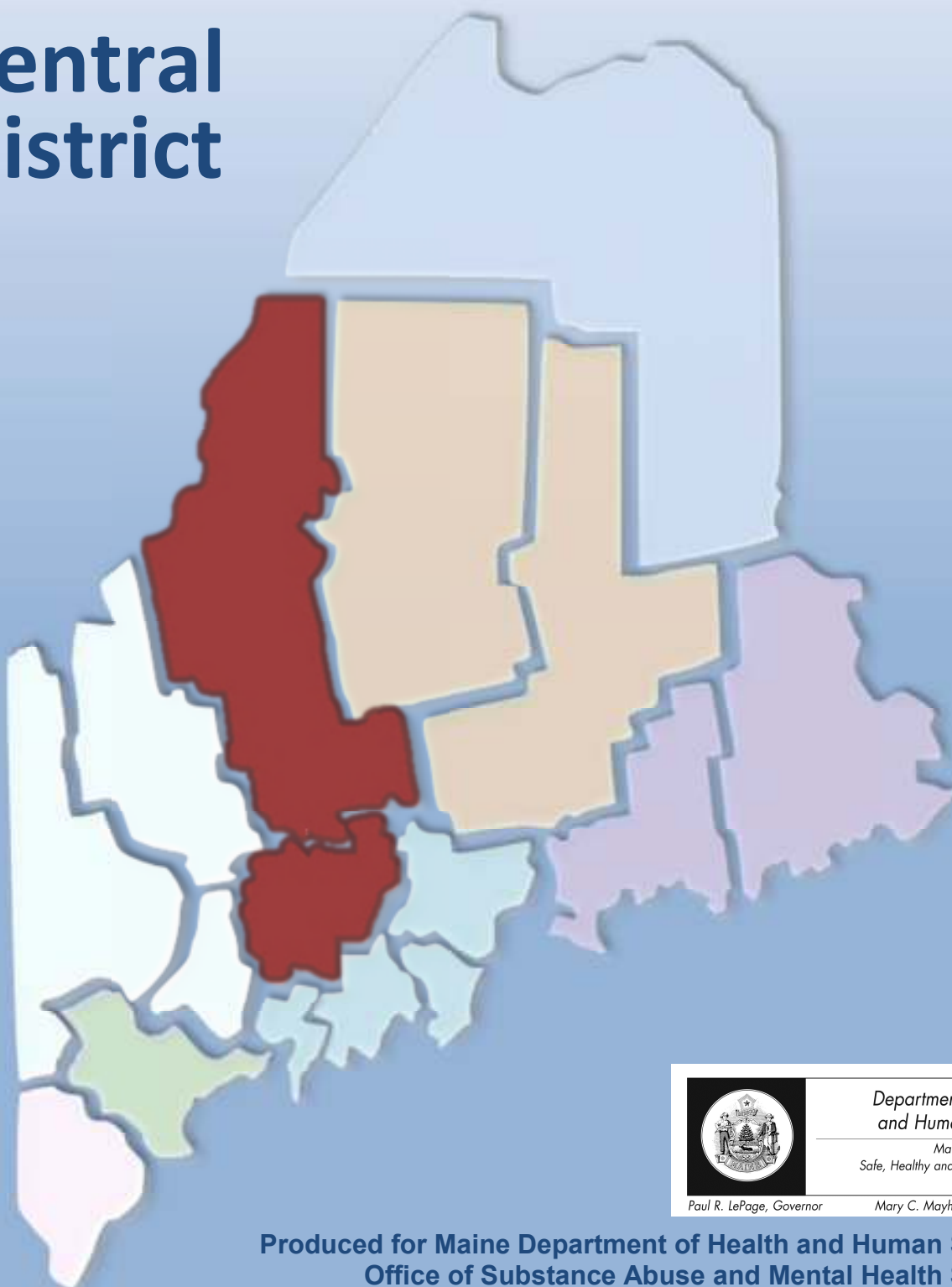


# Substance Abuse Trends in Maine

Epidemiological Profile 2013

## Central District



Department of Health  
and Human Services

*Maine People Living  
Safe, Healthy and Productive Lives*

Paul R. LePage, Governor

Mary C. Mayhew, Commissioner

Produced for Maine Department of Health and Human Services  
Office of Substance Abuse and Mental Health Services  
by Hornby Zeller Associates, Inc.  
July 2013

# **Substance Abuse Trends in Maine**

**Epidemiological Profile 2013**

## **Central District**

**THIS REPORT IS PRODUCED FOR  
THE MAINE OFFICE OF SUBSTANCE ABUSE  
COMMUNITY EPIDEMIOLOGY SURVEILLANCE NETWORK  
WITH SUPPORT FROM THE PARTNERSHIPS FOR SUCCESS GRANT THROUGH  
THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
SUBSTANCE ABUSE AND MENTAL HEALTH ADMINISTRATION**

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## Introduction

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### Overview of Central Public Health District

Central Public Health District has a population of 173,763 people, representing approximately 13 percent of Maine's total population in 2012. This is split between Kennebec County (121,853) and Somerset County (51,910). There are 36 people per square mile in the Central Public Health District as a whole. Kennebec County is home to Maine's capitol city, Augusta.

The State of Maine is considered an "aging" state, with 16 percent of the population being 65 years old and over, a higher rate than the US population as a whole (13%). In Central Public Health District, approximately 16 percent of the population was 65 years old or older in 2012. Approximately 97 percent of Central's population is Caucasian, followed by African American (.6%), Asian (0.7%), and American Indian and Alaska Native (0.5%). The median income of Kennebec and Somerset Counties are \$46,904 and \$37,875, respectively. Fourteen percent of the Central Public Health District is below the poverty level. Somerset has the fourth lowest income in the state, yet Kennebec has the sixth highest income in Maine. In sum, Central makes up a very cross-representational demographic view of the State.

It is within the context of these demographic characteristics that substance abuse in Central Public Health District (PHD) must be examined.

### Purpose of this Report

This report takes into account the primary objectives of the Office of Substance Abuse and Mental Health Services (SAMHS): to identify substance abuse patterns in defined geographical areas, establish substance abuse trends, detect emerging substances, and provide information for policy development and program planning. It also highlights all the prevention priorities identified in the SAMHS strategic plan: underage drinking, high-risk drinking, misuse of prescription drugs, and marijuana use. Finally, the report monitors many of the factors that contribute to substance use, such as access and perceptions of harm, as well as the common negative consequences such as crime, car crashes and overdose deaths.

This report includes data available through May 2013. Older and unchanged data are included when more recent data were not available. Five major types of indicators are included: self-reported substance consumption, consequences of substance use, factors contributing to substance use, indicators about mental health and substance abuse, and treatment admissions. The most recent data available for the Behavioral Risk Factor Surveillance System (BRFSS) are from 2011. **Due to methodological changes in weighting and sampling, 2011 BRFSS data cannot be trended with previous BRFSS years.** For this reason, we have only included snapshots of 2011 BRFSS data for this year's SEOW report. Previous county-level reports with older trending data are available at the <http://www.maine.gov/dhhs/samhs/> website.





## Consumption of Substances

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Consuming harmful substances can have detrimental effects on an individual's well-being, including increased risks of morbidity, addiction and mortality, and has a harmful effect on society as a whole including increased motor vehicle accidents and crime. However, it is the manner and frequency with which people drink, smoke and use drugs that are often linked to particular substance-related consequences. To understand fully the magnitude of substance use consequences, it is important to first understand the prevalence of substance use consumption, itself. Consumption includes overall use of substances, acute or heavy consumption and consumption by high risk groups (e.g., youth, college students, pregnant women).

As demonstrated by the indicators below, alcohol remains the substance most often used by Central PHD residents across the lifespan. In particular, high-risk drinking among the youth and younger adults (18-34) continues to be a concern, although it appears that high school students in Central PHD are somewhat less likely to engage in high-risk drinking compared to the rest of the state. Rates of youth cigarette smoking and smokeless tobacco use appear to be similar among Central PHDs population as compared to the state average whereas the Central PHD adult cigarette smoking is notably higher. Following closely behind alcohol and tobacco, marijuana and prescription drug misuse are the next two most commonly used drugs in Maine, and Central PHD is no different in that respect. Binge drinking and non-medical pain reliever use appear to be highest among Central PHD's 18 to 25 year old population.



## Alcohol

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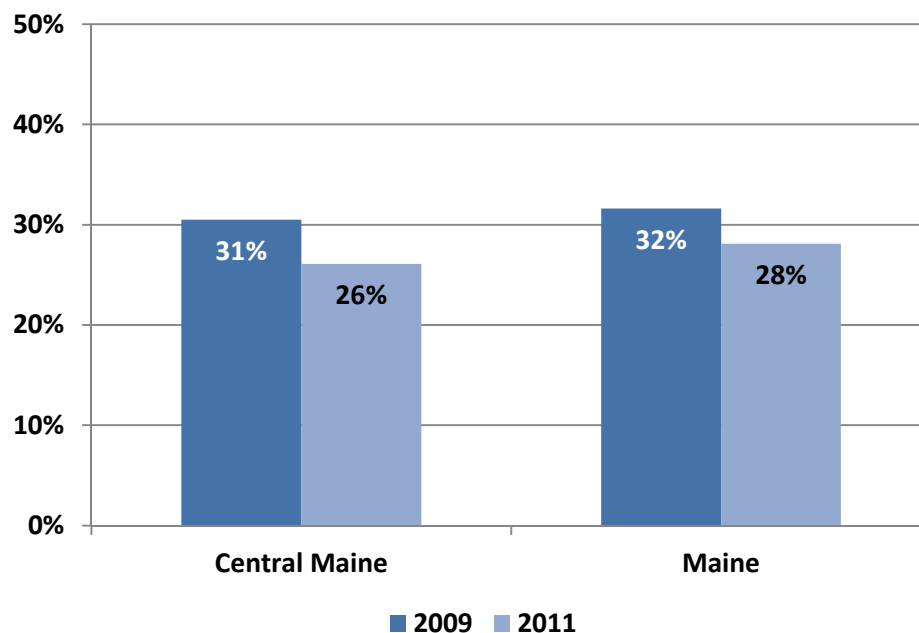
**Indicator Description: ALCOHOL USE AMONG YOUTH.** This measure shows the percentage of Maine high school students who reported having had one or more alcoholic drinks within 30 days prior to the survey.

**Why Indicator is Important:** Alcohol is the most often used substance among youth in Maine. In addition to the risks alcohol consumption carries for adults, developing adolescent brains are especially susceptible to the health risks of alcohol consumption. Adolescents who consume alcohol are more likely to have poor grades and be at risk for experiencing social problems, depression, suicidal thoughts, assault, and violence.

**Data Source(s):** MIYHS, 2009-2011.

**Summary:** In the Central PHD, the percentage of students who reported drinking in the past 30 days fell from 31 percent in 2009 to 26 percent in 2011; the percentage statewide decreased from 32 to 28 percent over the same timeframe.

**Figure 1. Percent of high school students in Central PHD who had at least one drink of alcohol during past 30 days: 2009, 2011**



Source: MIYHS

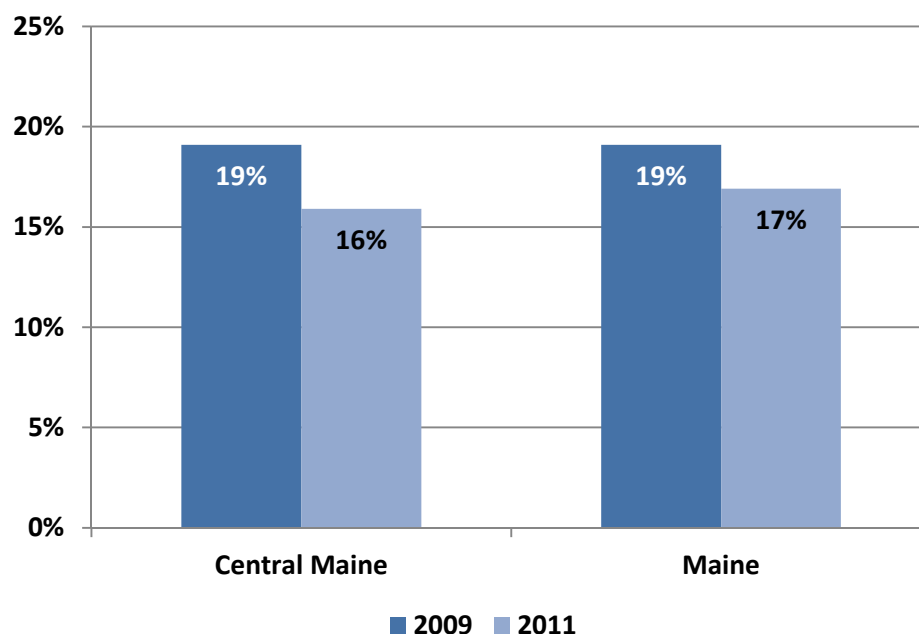
**Indicator Description: HIGH-RISK ALCOHOL USE AMONG YOUTH.** This indicator presents the percentage of Maine high school students who reported having had five or more alcoholic drinks in a row in one sitting at least once during the 30 days prior to the survey.

**Why Indicator is Important:** Youth are more likely than adults to engage in high-risk drinking when they consume alcohol. High risk alcohol use contributes to violence and motor vehicle crashes and can result in negative health consequences for the consumer, including injuries and chronic liver disease. Youth who engage in high-risk drinking also are more likely to use drugs and engage in risky and antisocial behavior.

**Data Source(s):** MIYHS, 2009-2011.

**Summary:** From 2009 to 2011, the percentage of high school students in Central PHD who reported having consumed five or more alcoholic beverages in one sitting during the past 30 days decreased from 19 percent to 16 percent. This is slightly lower than the statewide average (17%).

**Figure 2. Percent of high school students in Central PHD who had at least five drinks in a row during past 30 days: 2009, 2011**



Source: MIYHS

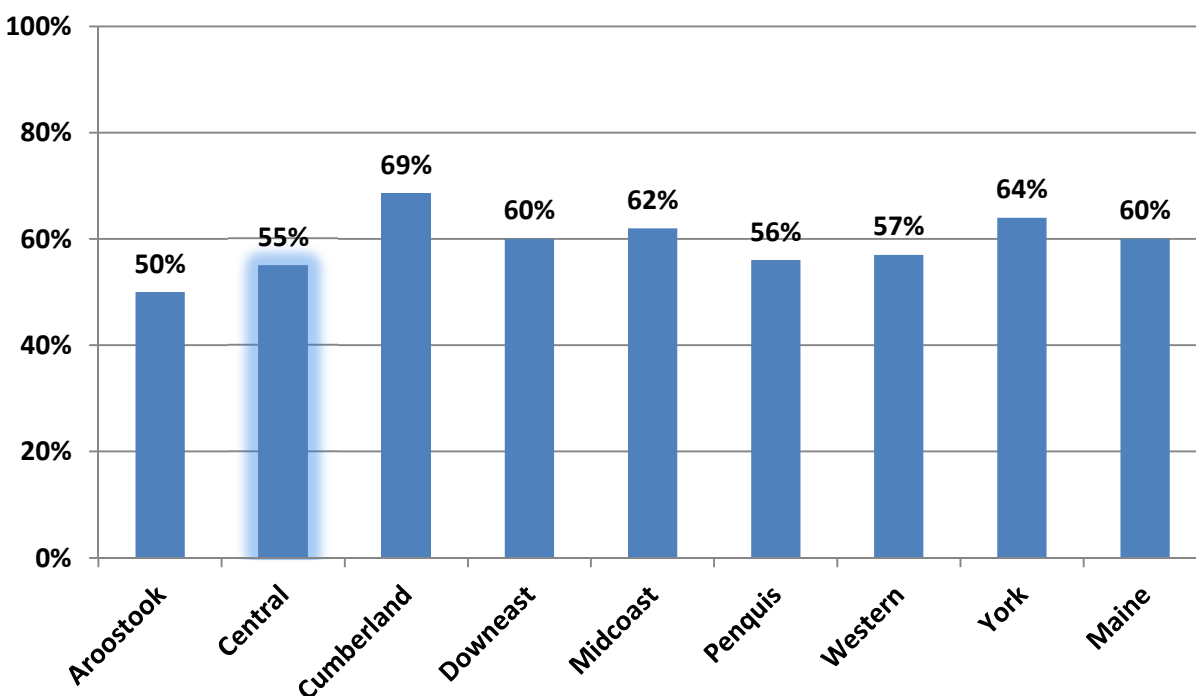
**Indicator Description: ALCOHOL USE AMONG ADULTS.** This indicator portrays the percentage of adults who reported having consumed one or more alcoholic drinks on one or more days within the past 30 days.

**Why Indicator is Important:** Alcohol is the most often used substance in Maine adults. Excessive and high risk alcohol use may contribute to violence and result in many negative health consequences for the consumer. Moderate drinking can also have negative health effects and lead to such consequences as alcohol-related motor vehicle crashes and increased injuries. Current alcohol use in pregnant women is also linked to low birth weight babies, sudden infant death, and other developmental delays in children.

**Data Source(s):** BRFSS, 2011.

**Summary:** In 2011, 55 percent of adults in Central PHD reported drinking at least one alcoholic beverage within the past 30 days; this was notably lower than the statewide average of 60 percent and second lowest among public health districts.

**Figure 3. Percent of adults by Public Health District who reported drinking during past 30 days: 2011**



Source: BRFSS

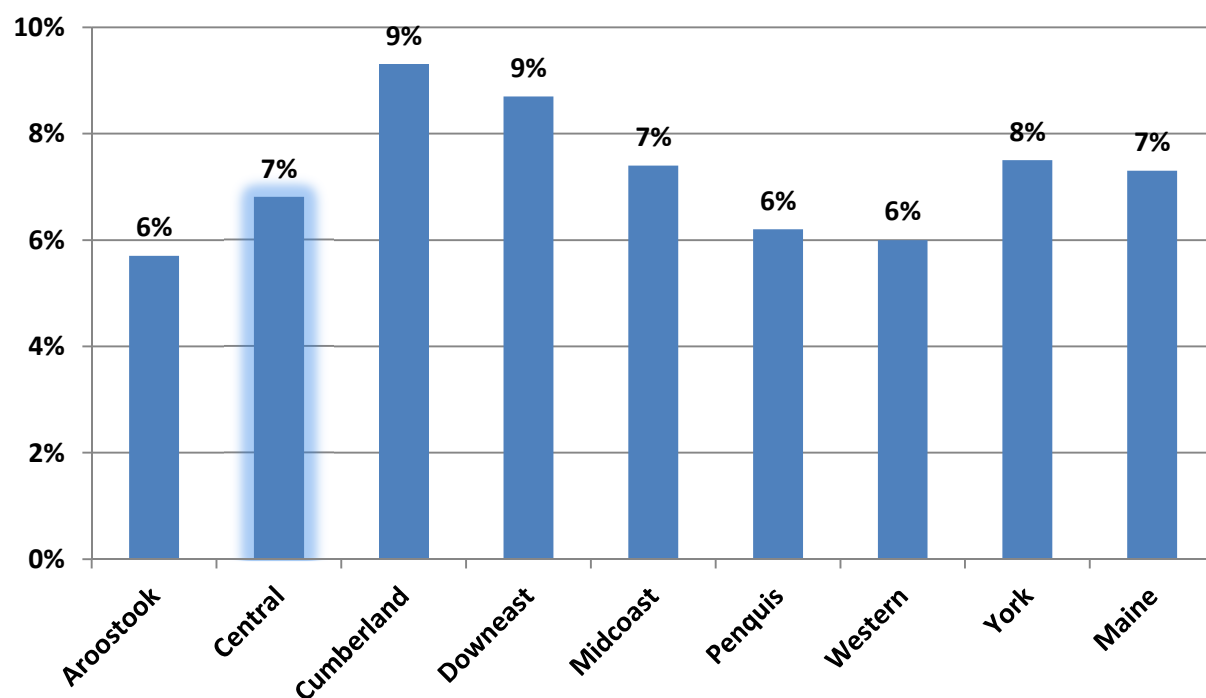
**Indicator Description: AT RISK FROM HEAVY ALCOHOL USE.** This indicator examines the percentage of Maine residents who are at risk from heavy drinking in the past month. Heavy drinking is defined as two drinks per day for a man or one drink per day for a woman.

**Why Indicator is Important:** Heavy drinking increases the risk for many health and social related consequences. People who consume alcohol heavily are at increased risk for a variety of negative health consequences, including alcohol abuse and dependence, liver disease, certain cancers, pancreatitis, heart disease, and death. It has also been found that the more heavily a person drinks the greater the potential for problems at home, work, and with friends.<sup>1</sup>

**Data Source(s):** BRFSS, 2011.

**Summary:** In 2011, seven percent of adults in the Central PHD indicated to be at risk from heavy alcohol use (1-2 drinks per day). This rate was the same as the statewide average.

**Figure 4. Percent of adults by Public Health District who reported heavy drinking during past 30 days: 2011**



Source: BRFSS

<sup>1</sup> Citation from Alcoholscreening.org, a service of Join Together and the Boston University School of Public Health. Retrieved from <http://www.alcoholscreening.org/Learn-More.aspx?topicID=8&articleID=26> on 5/5/2011.

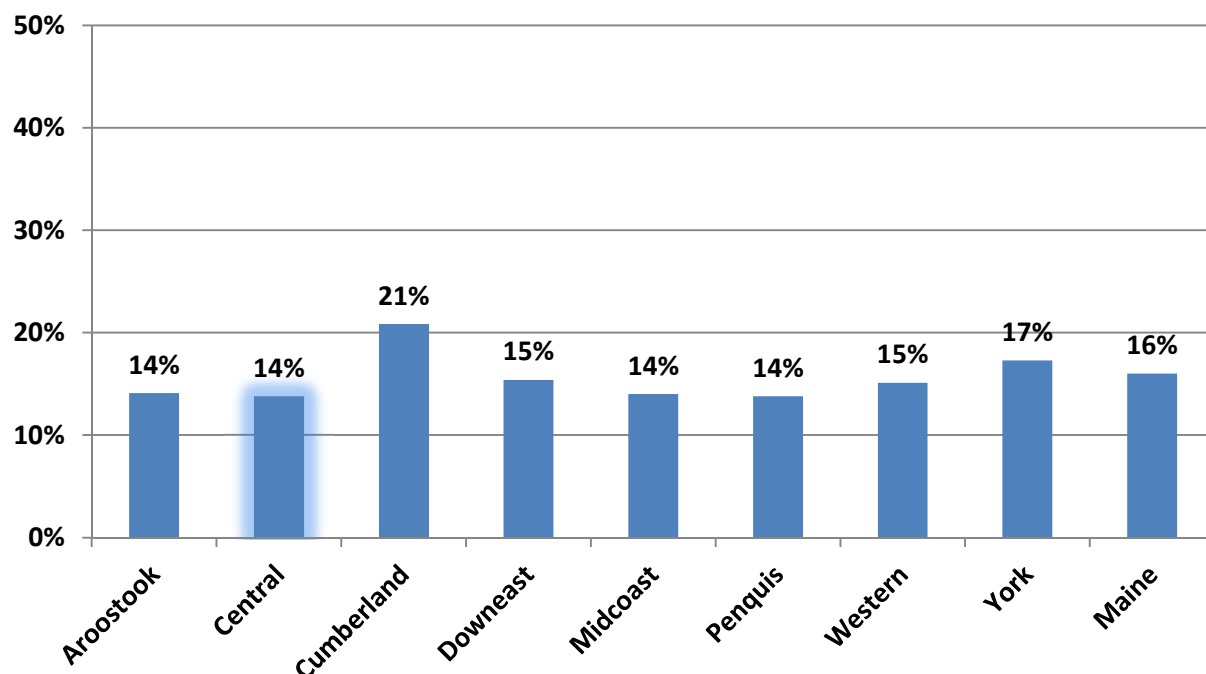
**Indicator Description: HIGH-RISK ALCOHOL USE AMONG ADULTS.** This indicator reflects the percentage of adults who reported engaging in high-risk “binge” drinking within the past 30 days. This is defined as five or more drinks in one sitting for a male and four or more drinks in one sitting for a female.

**Why Indicator is Important:** Binge drinking is considered to be a type of high-risk drinking, meaning it increases the risk for many health- and social-related consequences. It has been linked to injury (such as falls, fights, and suicides), violence, crime rates, motor vehicle crashes stroke, chronic liver disease, addiction, and some types of cancer.

**Data Source(s):** BRFSS, 2011.

**Summary:** In 2011, 14 percent of adults in the Central PHD indicated they engaged in binge drinking during the past 30 days. This was two percentage points lower than the statewide average (16%) and among the lowest rates of the public health districts.

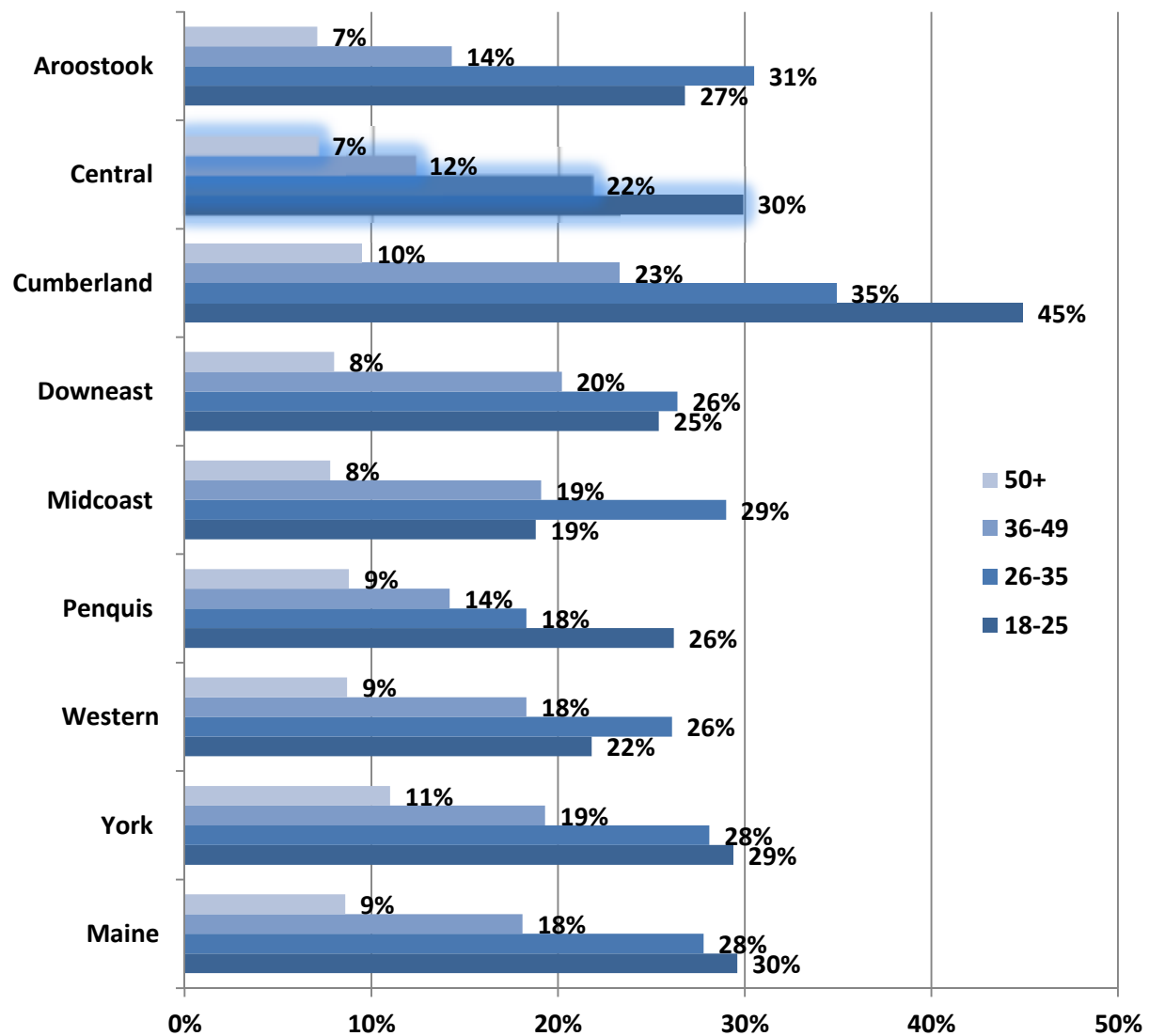
**Figure 5. Percent of adults by Public Health District who reported binge drinking during past 30 days: 2011**



Source: BRFSS

**Summary:** In 2011, the highest rate of binge drinking in Central PHD was among the 18 to 25 year old population at 30 percent; this was same as the statewide. The second highest binge drinking rate in Central PHD was among 26 to 35 year olds at 22 percent, followed by 36 to 49 year olds (12%), and residents over the age of 50 (7%).

**Figure 6. Percent of adults by Public Health District who reported binge drinking in past 30 days by age group: 2011**



Source: BRFSS



## Tobacco

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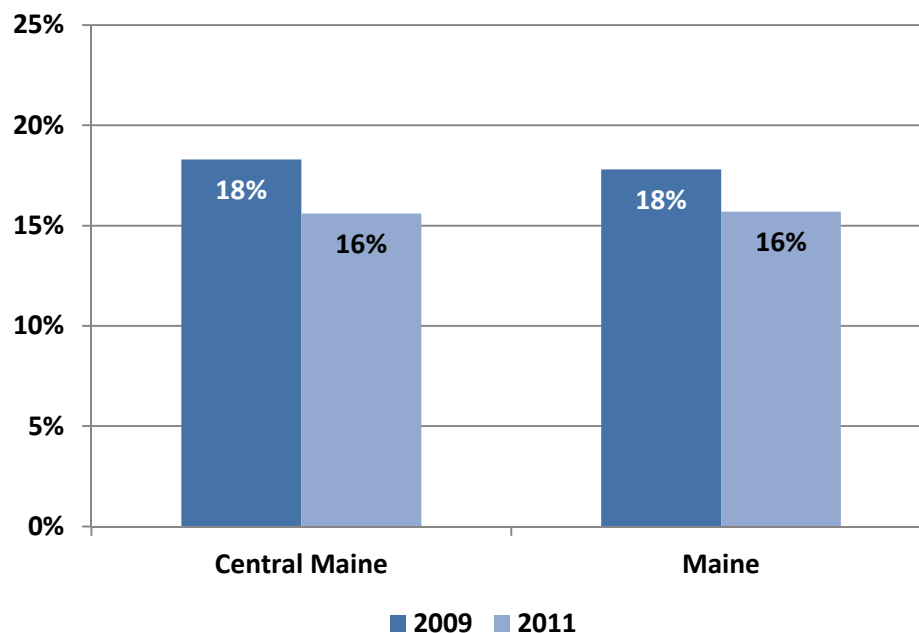
**Indicator Description: SMOKING AMONG YOUTH.** This indicator illustrates the percentage of Maine high school students who reported smoking a cigarette on at least one occasion within 30 days prior to the survey.

**Why Indicator is Important:** Use of tobacco is associated with a greater risk of negative health outcomes, including cancer, cardiovascular, and chronic respiratory diseases, as well as death.

**Data Source(s):** MIYHS, 2009-2011.

**Summary:** From 2009 to 2011 the percentage of high school students in Central PHD who reported having smoked one or more cigarettes in the past 30 days decreased from 18 percent to 16 percent.

**Figure 7. Percent of high school students in Central PHD who reported smoking one or more cigarettes during past 30 days: 2009, 2011**



Source: MIYHS

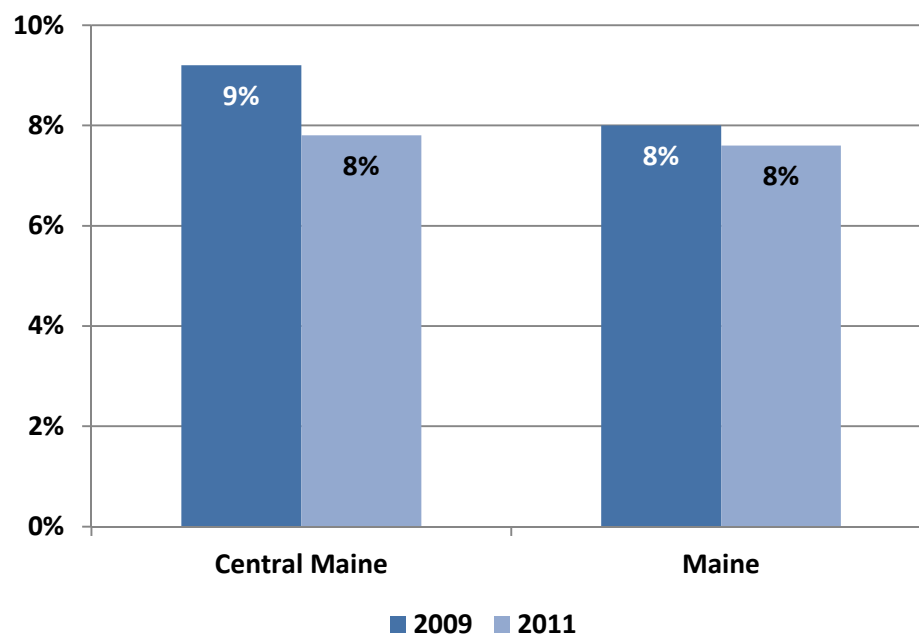
**Indicator Description: SMOKELESS TOBACCO AMONG YOUTH.** This indicator illustrates the percentage of Maine high school students who reported using smokeless tobacco on at least one occasion within 30 days prior to the survey.

**Why Indicator is Important:** Use of tobacco is associated with a greater risk of negative health outcomes, including cancer, cardiovascular and chronic respiratory diseases, as well as death.

**Data Source(s):** MIYHS, 2009-2011.

**Summary:** The percentage of high school students in Central PHD who have used smokeless tobacco in the past 30 days is the same as the statewide average (8%).

**Figure 8. Percent of high school students in Central PHD who used smokeless tobacco in the past 30 days: 2009, 2011**



Source: MIYHS

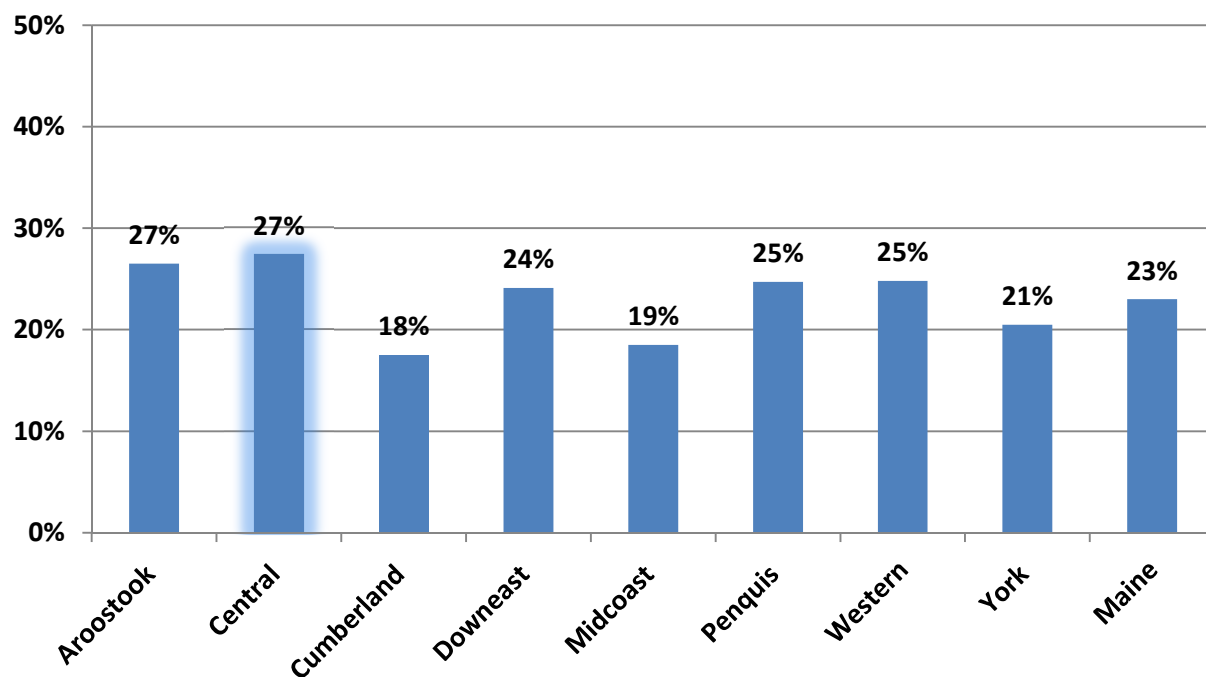
**Indicator Description: SMOKING AMONG ADULTS.** This indicator illustrates the percentage of Maine adults who reported using cigarettes on at least one occasion within 30 days prior to the survey.

**Why Indicator is Important:** Smoking is associated with a greater risk of negative health outcomes, including cancer, cardiovascular and chronic respiratory diseases, as well as death.

**Data Source(s):** BRFSS, 2011.

**Summary:** In 2011, 27 percent of adults in Central PHD indicated they had smoked a cigarette in the past 30 days, four percentage points higher than the statewide average of 23 percent.

**Figure 9. Percent of adults by Public Health District who reported smoking a cigarette in the past 30 days: 2011**



Source: BRFSS

## Prescription Drugs

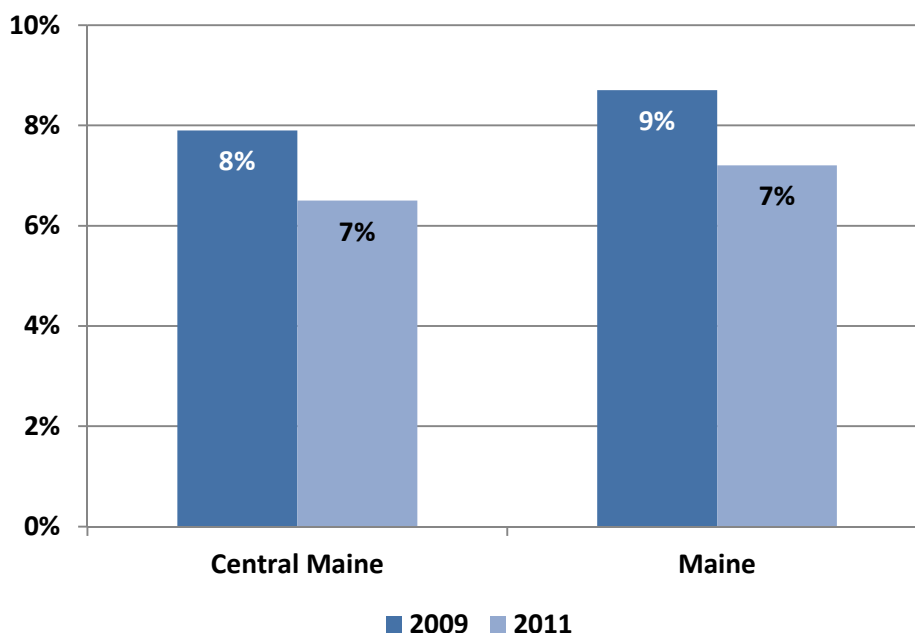
**Indicator Description: MISUSE OF PRESCRIPTION DRUGS AMONG YOUTH.** This indicator presents the percentage of Maine high school students who reported using prescription drugs that were not prescribed to them by a doctor within 30 days prior to the survey.

**Why Indicator is Important:** Young people are increasingly using available prescription drugs, including stimulants and opiates, instead of illegal drugs to get high. Abuse of prescription drugs may lead to consequences such as unintentional poisonings or overdose, automobile crashes, addiction, and increased crime.

**Data Source(s):** MIYHS, 2009-2011.

**Summary:** In 2011, seven percent of high school students in Central PHD reported having taken prescription drugs not prescribed to them by a doctor one or more times in the past 30 days; this was the same as the statewide rate.

**Figure 10. Percent of high school students in Central PHD who have taken prescription drugs not prescribed to them by a doctor: 2009, 2011**



Source: MIYHS

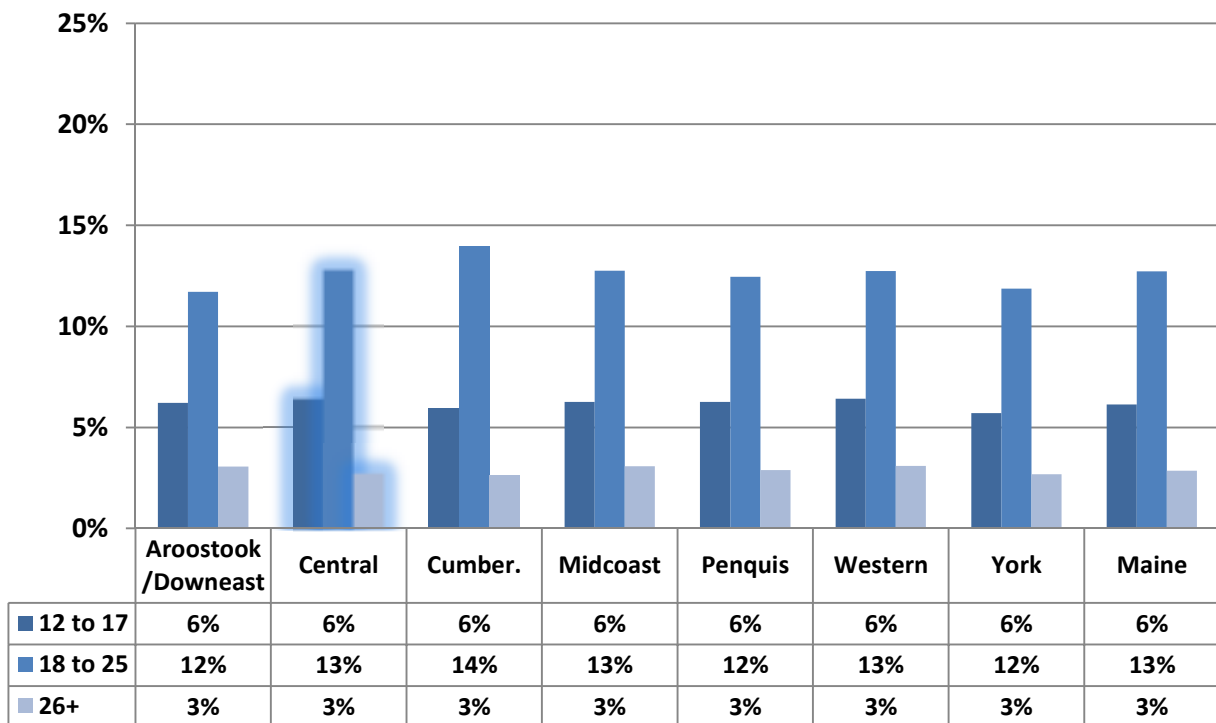
**Indicator Description: NONMEDICAL USE OF PRESCRIPTION PAIN RELIEVERS AMONG MAINERS AGE 12 AND OLDER.** This measure reflects the percentage of adults who reported using prescription drugs, particularly prescription pain relievers, for reasons other than their intended purpose. Because of small sample sizes, survey data from multiple years must be combined in order to produce this estimate.

**Why Indicator is Important:** Mainers are increasingly using available prescription drugs, particularly pain relievers, instead of illegal drugs to get high. Abuse of prescription drugs may lead to consequences such as unintentional poisonings, overdose, dependence and increased crime.

**Data Source(s):** NSDUH, 2008-10.

**Summary:** In 2008-10, 13 percent of 18 to 25 year olds in Central PHD reported non-medical use of prescription pain relievers during the past 30 days, higher than any other age group within the district. Although not shown, rates of non-medical pain reliever among residents 12 and older in Central PHD did not change since 2006-08 (4.2% in both years).

**Figure 11. Percent of population 12 years old or older who used prescription pain relievers in past year for nonmedical use, by Public Health District: 2008-10**



Source: NSDUH

## Other Illegal Drugs

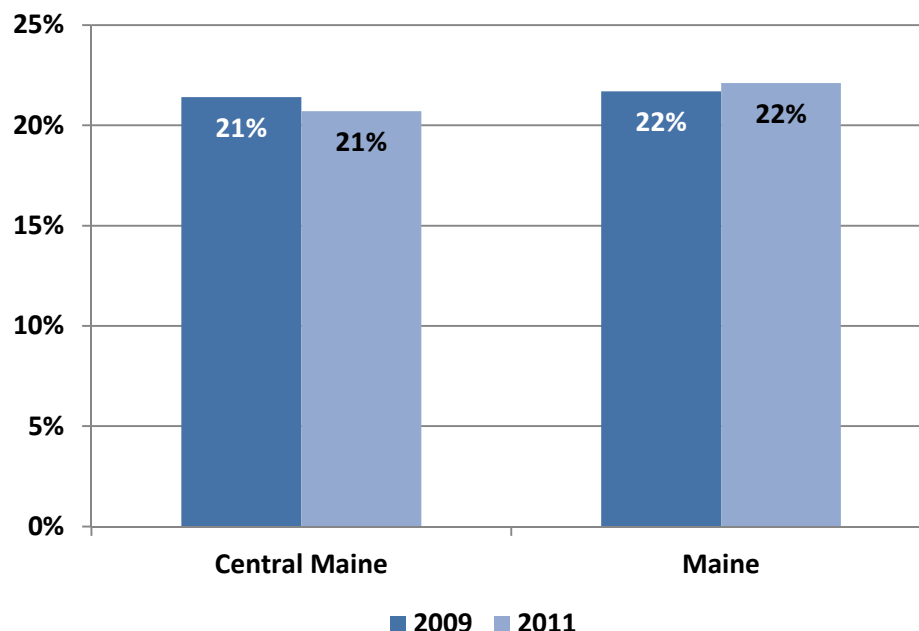
**Indicator Description: CURRENT MARIJUANA USE.** This measure shows the percentage of Maine residents who reported using marijuana in the past 30 days. This is presented for high school students and adults in Maine.

**Why Indicator is Important:** Marijuana can be addictive and is associated with increased risk for respiratory illnesses and memory impairment. Even occasional use can have consequences on learning and memory, muscle coordination, and mental health symptoms.

**Data Source(s):** MIYHS, 2009-2011; BRFSS 2011.

**Summary:** Twenty-one percent of high school students in Central PHD reported having used marijuana one or more times in the past 30 days, slightly more than the statewide rate (22%).

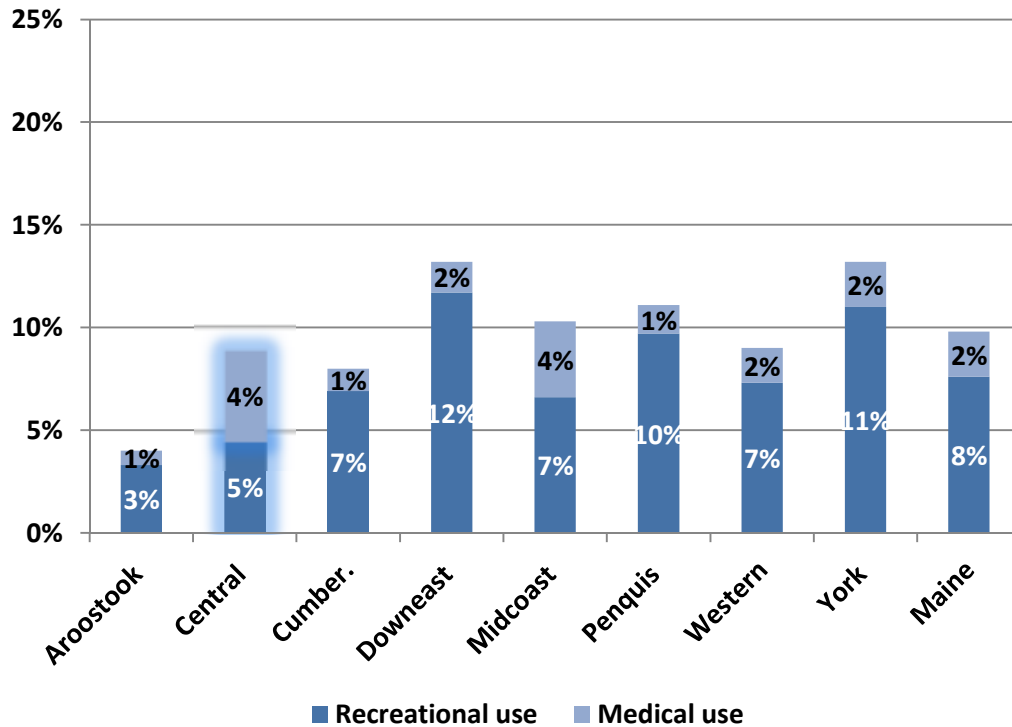
**Figure 12. Percent of high school students in Central PHD who have used marijuana during past 30 days: 2009, 2011**



Source: MIYHS

**Summary:** Among Central PHD adults, five percent reported using marijuana recreationally, and four percent reported using marijuana for medical reasons. This is the highest rate of medical use in the state. With the inception of medicinal marijuana in Maine, marijuana medical use rates are expected to increase over the next few years.

**Figure 13. Percent of adults who have used marijuana during the past 30 days, by Public Health District: 2011**



Source: BRFSS

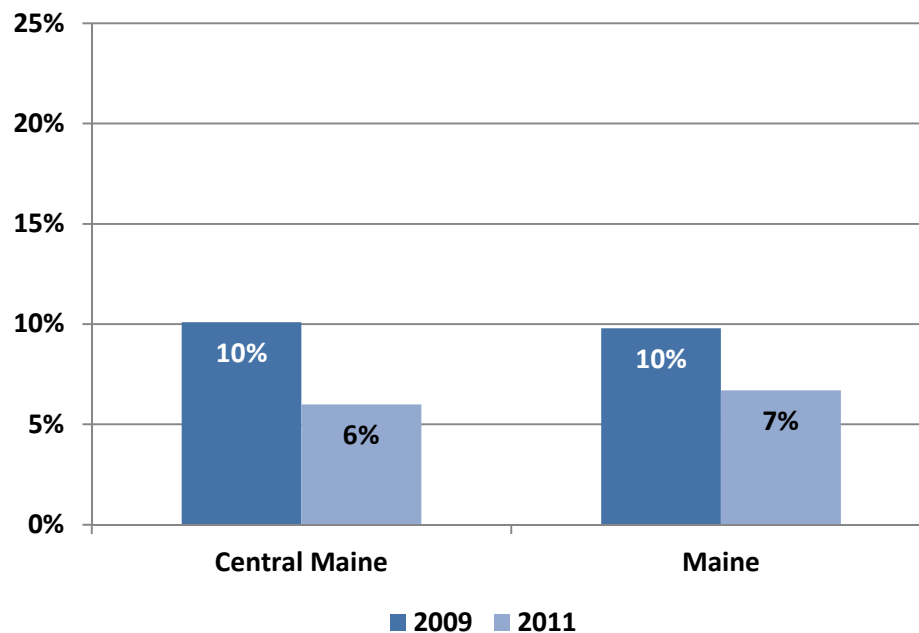
**Indicator Description: LIFETIME COCAINE USE AMONG YOUTH.** This indicator illustrates the percentage of Maine high school students who used cocaine at least once in their lifetime (i.e., ever).

**Why Indicator is Important:** Cocaine is highly addictive. Use of cocaine is associated with adverse health effects such as cardiac events, seizures, and stroke. It also increases the risk of cognitive impairment, injury, and crime.

**Data Source(s):** MIYHS, 2009-2011.

**Summary:** From 2009 to 2011, the rate of high school students reporting that they had used cocaine (in any form) during their lifetime decreased by four percentage points. The proportion of students reporting such usage in Central PHD is slightly less than the statewide average (7%).

**Figure 14. Percent of high school students in Central PHD that have used cocaine in any form during their lifetime: 2009, 2011**



Source: MIYHS



## Consequences Resulting from Substance Use and Abuse

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Both individuals and communities suffer the consequences of substance abuse in terms of increased health care needs and criminal justice resources. While a great deal of information regarding substance use can be obtained from the data described in the previous section, information on the effects of that use on individuals and communities can be derived from what has come to be called “consequence” data. Consequences are defined as the social, economic and health problems associated with the use of alcohol and illicit drugs. Examples are things such as illnesses related to alcohol, drug overdose deaths, property and personal crimes, as well as driving accidents, poisonings and suicides that involve alcohol or drugs.

When adjusted for population differences, rates indicating alcohol-related arrests, inpatient admissions due to substance use, and overdoses appear to be higher in Central PHD than those statewide. In contrast rates measuring drug-related arrests and alcohol/drug-related crash rates are somewhat lower than the state and seem to be decreasing over the past several years. Central PHD had the second highest rate of outpatient admissions due to opiates, and the rate of EMS responses to overdoses almost doubled between 2010 and 2011; these tend to be related to medications, rather than alcohol. Overdose deaths may be leveling off, however.



## Criminal Justice Involvement

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**Indicator Description: ANNUAL VIOLENT CRIME RATE.** This indicator shows the number of violent crimes reported to the police, per 10,000 people. Violent crimes include simple and aggravated assaults, sexual assaults, and robberies. The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas.

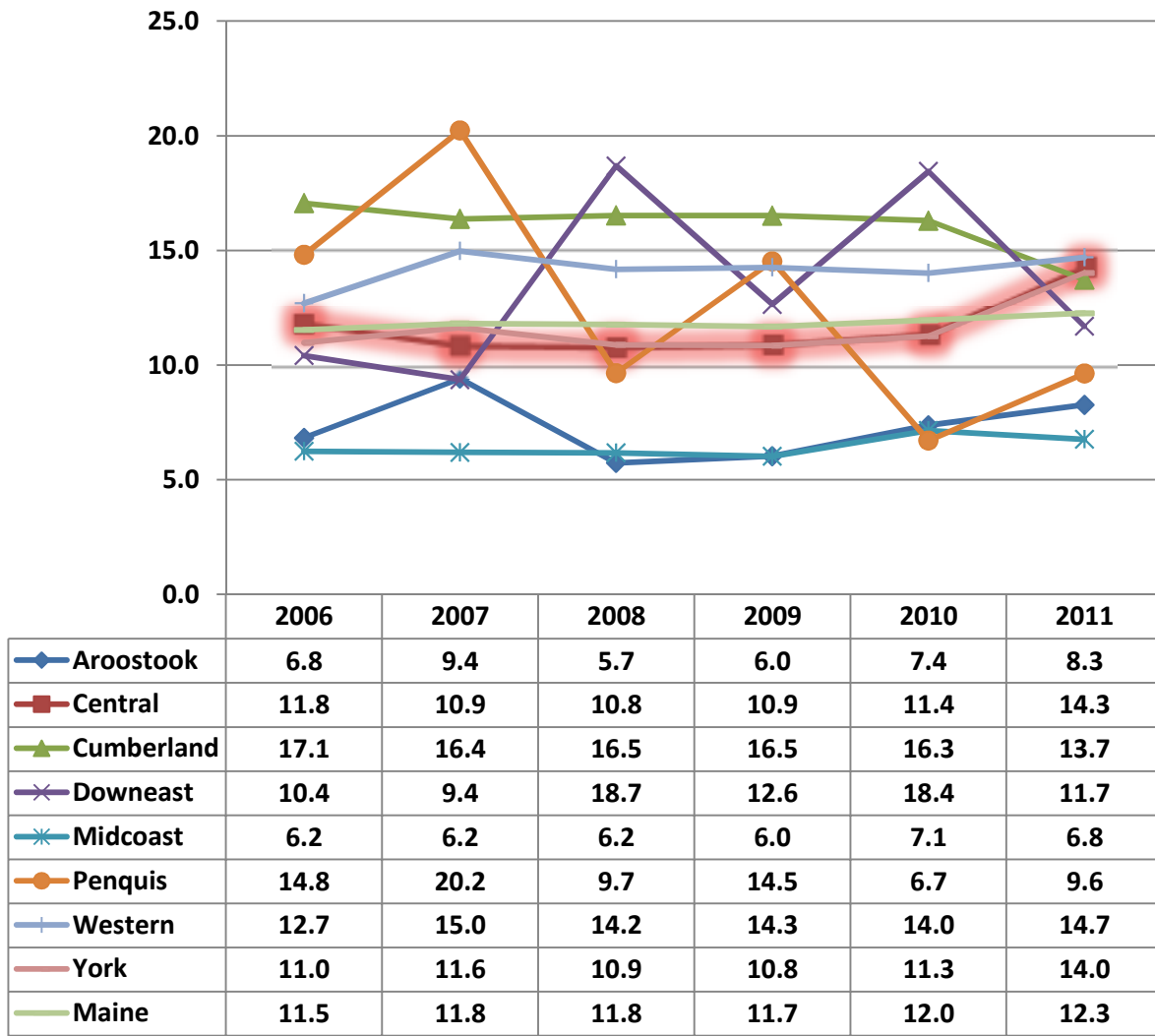
Operationalized as:  $\left( \frac{\# \text{ of violent crimes}}{\text{population}} \right) \times 10,000$

**Why Indicator is Important:** Violence is associated with alcohol, though the causal pathway is not completely understood. Drinking on the part of the victim or a perpetrator can increase the risk of assaults and assault-related injuries. Approximately 23 percent of sexual assaults and 30 percent of physical assaults are attributable to alcohol. Reported violent crimes are an under-report of the total number of actual violent crimes.

**Data Source(s):** DPS, UCR, 2006-2011.

**Summary:** In 2011, there were 14.3 violent crimes per 10,000 people in Central PHD; this was higher than the statewide rate (12.3 per 10,000) and second highest among public health districts. Violent crime rates have been gradually increasing since 2008.

Figure 15. Violent crime rate per 10,000, by Public Health District:  
2006-2011



Source: DPS; UCR

**Indicator Description: ANNUAL ALCOHOL-RELATED ARREST RATE.** This indicator reflects arrests related to alcohol per 10,000 people. Alcohol-related arrests include Operating Under the Influence (OUI), liquor law violations, and drunkenness. The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas.

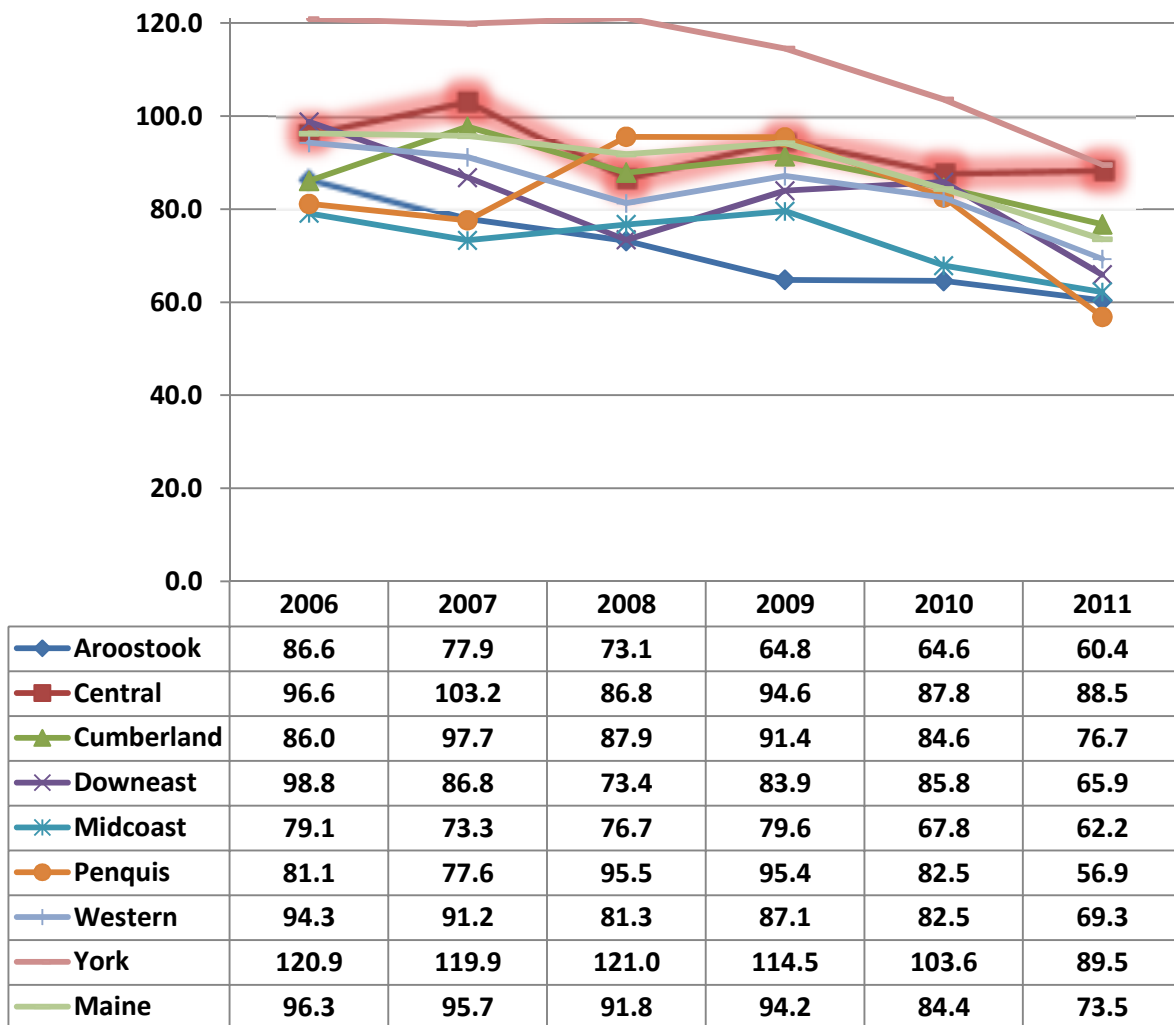
Operationalized as:  $\left( \frac{\# \text{ of alcohol arrests}}{\text{population}} \right) \times 10,000$

**Why Indicator is Important:** OUI and liquor law arrest rates can be an indication of the rate of criminal behavior, but it is important to note that they are also an *indication of the level of law enforcement*. Arrest rates are expected to increase with increased enforcement regardless of whether a decline in criminal behavior is observed. The educational component of Maine's Driver Education and Evaluation Program serviced 5,500 Maine residents in 2012.

**Data Source(s):** DPS, UCR, 2006-2011.

**Summary:** In 2011, Central PHD had 88.5 alcohol-related arrests per 10,000 people, compared to the statewide rate of 73.5 per 10,000. Central PHD held the second highest alcohol-related arrest rate among public health districts in 2011. Alcohol-related arrest rates have been relatively stable for Central PHD since 2008.

**Figure 16. Alcohol-related arrest rate per 10,000, by Public Health District:  
2006-2011**



Source: DPS; UCR

**Indicator Description: ANNUAL DRUG-RELATED ARREST RATE.** This indicator reflects the number of arrests that were related to drugs per 10,000 people. Drug-related arrests include manufacturing, sales, and possession. The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time as well as make relative comparisons between small and large population areas.

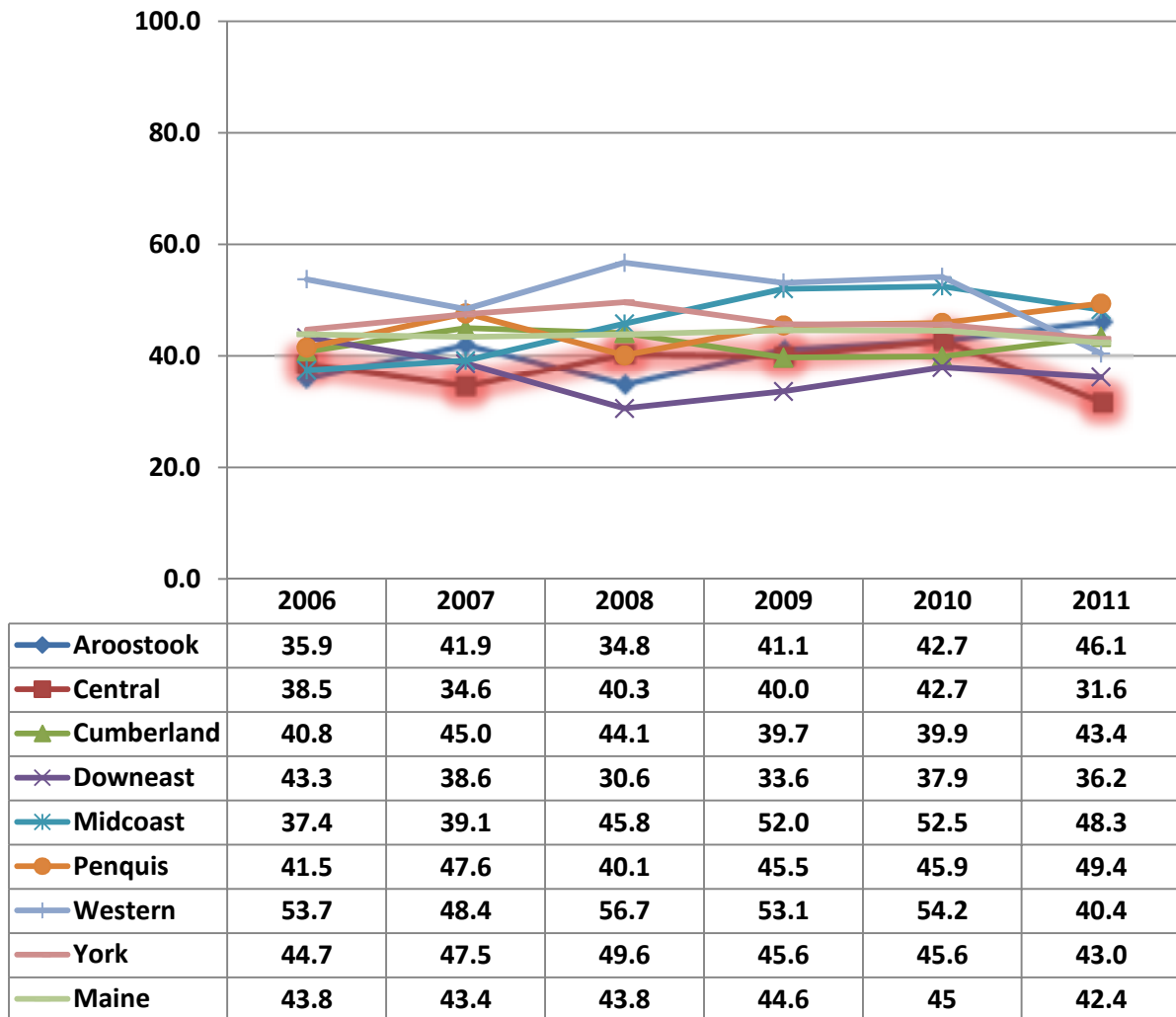
Operationalized as:  $\left( \frac{\# \text{ of drug arrests}}{\text{population}} \right) \times 10,000$

**Why Indicator is Important:** Arrest rates for drug sales, manufacturing and drug possession can be an indication of the rate of criminal behavior, but it is important to note that they are also an *indication of the level of law enforcement*. Arrests rates are expected to increase with increased enforcement regardless of whether a decline in criminal behavior is observed.

**Data Source(s):** DPS, UCR, 2006-2011.

**Summary:** In 2011, there were 31.6 drug-related arrests per 10,000 people in Central PHD; this was significantly lower than the statewide rate (42 per 10,000) and lowest among public health districts. For the past several years, Central PHD has had comparatively low rates of alcohol-related arrests.

**Figure 17. Drug-related arrest rate per 10,000, by Public Health District:  
2006-2011**



Source: DPS; UCR



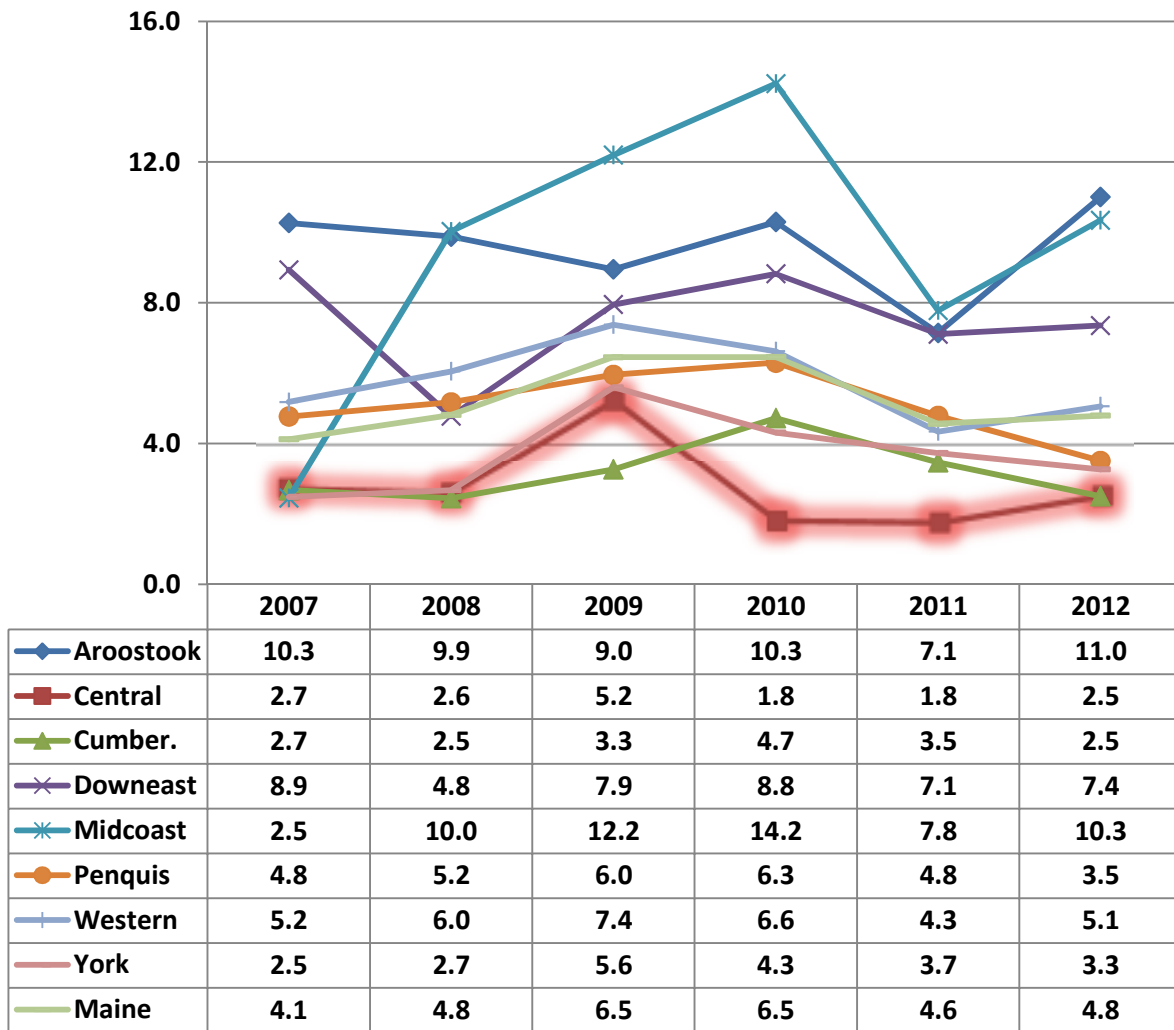
**Indicator Description: DRUG OFFENSE ARRESTS BY TYPE.** This indicator reflects drug offense arrests made by the Maine’s Drug Enforcement Agency, overall and by drug type. The MDEA, through its eight regional multi-jurisdictional task forces, is the lead state agency in confronting drug trafficking crime. This indicator differs from the previous drug-related arrest data in that it only tracks MDEA efforts and does not encompass all activity within Maine law enforcement agencies.

**Why Indicator is Important:** Drug offense arrest rates can be an indication of the rate of criminal behavior, but it is important to note that they are also an indication of the level of law enforcement. Drug arrest rates are expected to increase with increased enforcement regardless of whether a decline in criminal behavior is observed.

**Data Source(s):** MDEA-UCR, 2007-2012

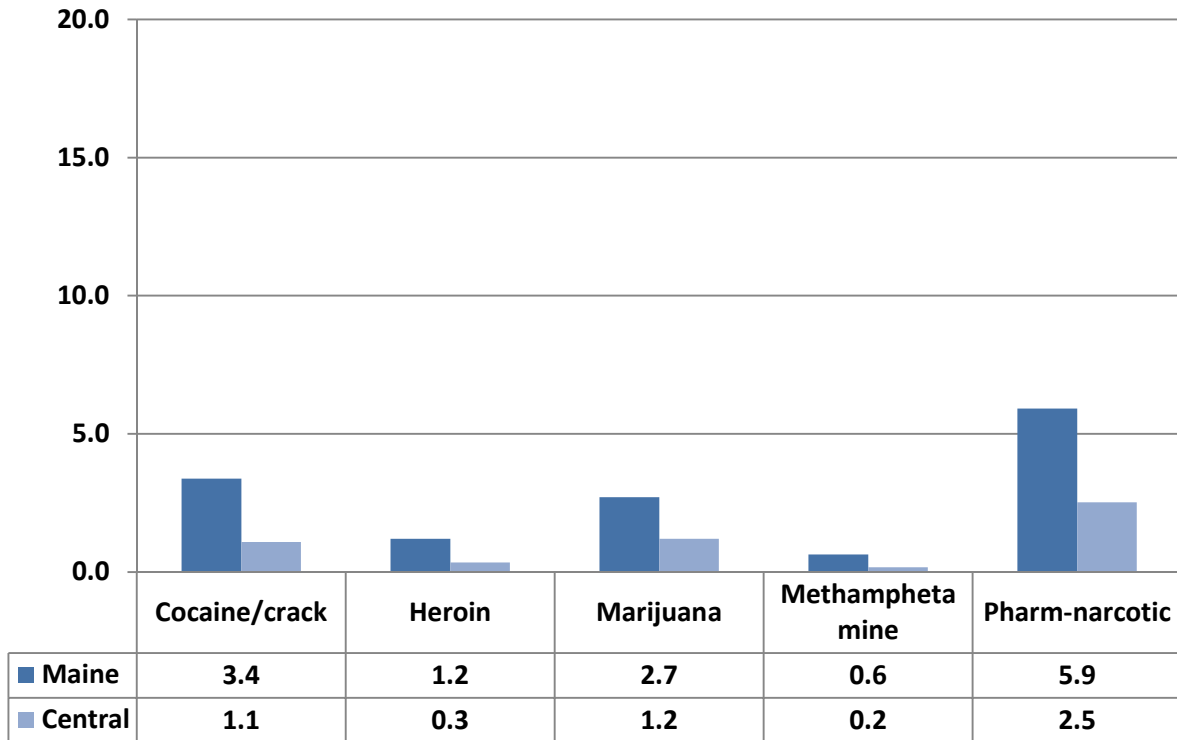
**Summary:** There were 2.5 drug offense arrests per 10,000 residents in Central PHD in 2012. Rates in Central PHD have remained relatively low since 2007. In 2012, most drug offense arrests in Central PHD were related to pharmaceutical narcotics (2.5 arrests per 10,000) followed by marijuana (1.2 arrests per 10,000).

Figure 18. Drug offense arrests per 10,000 residents, by  
Public Health District: 2007-2012



Source: MDEA-UCR

**Figure 19. Drug offense arrests per 10,000 residents in  
Central PHD, by drug type: 2009-12**



Source: MDEA-UCR

## Driving Under the Influence

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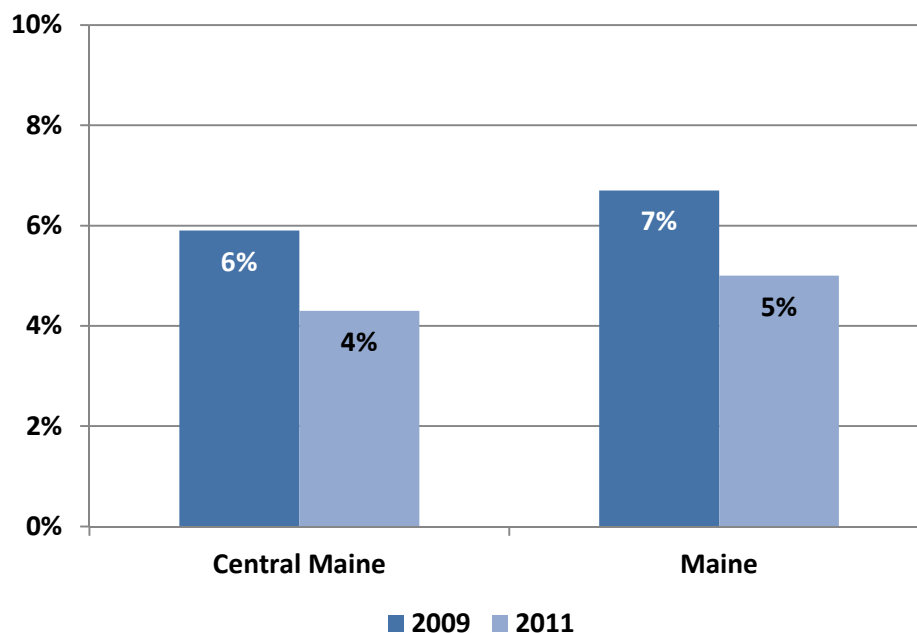
**Indicator Description: DRINKING AND DRIVING AMONG YOUTH.** This measure shows the proportion of high school students who reported that they drove a car after consuming alcohol at least once within 30 days prior to taking the survey.

**Why Indicator is Important:** Operating a vehicle after consuming alcohol increases the risk of motor vehicle crashes, injuries and death.

**Data Source(s):** MIYHS, 2009-2011.

**Summary:** Approximately four percent of high school students in Central PHD reported driving a vehicle at least once after drinking alcohol in the past 30 days. This rate is slightly less than the statewide average.

**Figure 20. Percent of high school students in Central PHD who reported drinking and driving during the past 30 days: 2009, 2011**



Source: MIYHS

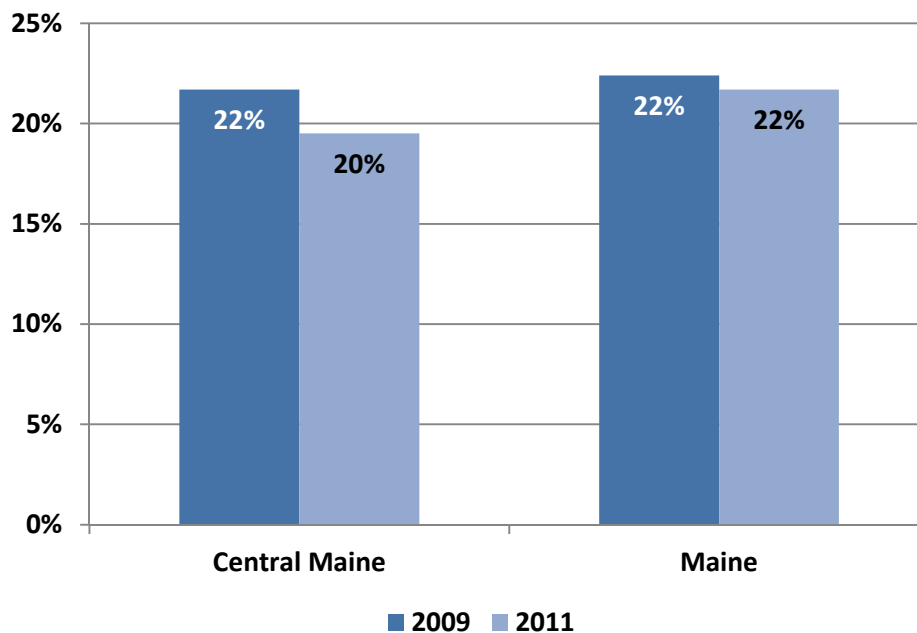
**Indicator Description: YOUTH AS PASSENGERS IN VEHICLES DRIVEN BY INDIVIDUALS USING ILLEGAL DRUGS.** This measure shows the proportion of high school students who reported that within 30 days prior to taking the survey they were a passenger in a car being operated by an individual who had consumed illegal drugs.

**Why Indicator is Important:** Operating a vehicle while under the influence of drugs increases the risk of motor vehicle crashes, injuries and death.

**Data Source(s):** MIYHS, 2009-2011.

**Summary:** Twenty percent of high school students in Central PHD reported that, within the past 30 days, they had been passengers in a vehicle operated by someone who had taken illegal drugs compared to 22 percent across the state.

**Figure 21. Percent of high school students in Central PHD who rode in a vehicle driven by someone who had taken illegal drugs: 2009, 2011**



Source: MIYHS

**Indicator Description:** **ALCOHOL/DRUG-INVOLVED MOTOR VEHICLE CRASH RATE.** This indicator shows the number of motor vehicle crashes in which alcohol or drugs were a factor per 10,000 people. Due to new data collection regulations, crash rate data is no longer separated by alcohol and drugs. Alcohol and drugs are now combined into one rate. Alcohol/drug-involved crashes means that at least one driver had consumed alcohol or drugs prior to the crash. The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas.

Operationalized as:  $\left( \frac{\# \text{ of alcohol/drug-involved crashes}}{\text{population}} \right) \times 10,000$

**Why Indicator is Important:** Motor vehicle crashes are the second-leading cause of traumatic brain injury, with 27 percent of traumatic brain injuries occurring from motor vehicle crashes.<sup>2</sup> In the 2009, alcohol was attributed to 96 percent of the alcohol/drug-related crashes statewide.

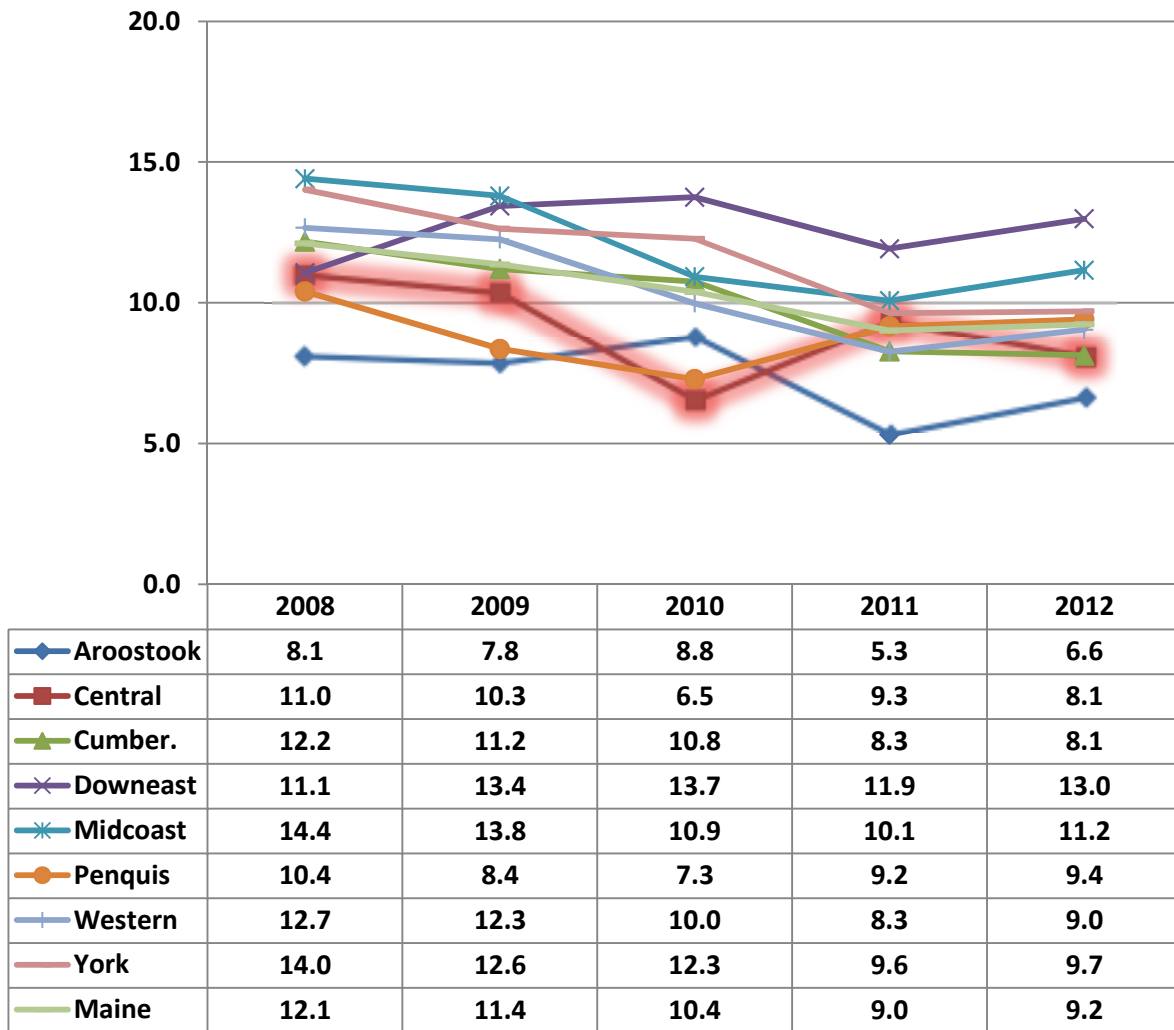
**Data Source(s):** MDOT/MBHS, 2008-2012.

**Summary:** In Maine and in Central PHD, the rates of alcohol-related crashes have been declining overall since 2008. In 2012, there were 8.1 alcohol-related crashes per 10,000 people in Central PHD; this was lower than the statewide rate (9.2 per 10,000) and second lowest among public health districts.

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<sup>2</sup> 2007 Maine Injury Report, Maine Center for Disease Control, Injury Prevention Program. Retrieved 5/17/2012 from <http://www.maine.gov/dhhs/mecdc/population-health/inj/documents/2007maineinjuryreport.pdf>

Figure 22. Alcohol/Drug-related motor vehicle crash rate per 10,000,  
by Public Health District: 2008-2012



Source: MDOT/MBHS

## Hospital Visits Related to Substance Use

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**Indicator Description: INPATIENT ADMISSIONS RELATED TO SUBSTANCE USE.** This indicator shows the number of inpatient hospital admissions (per 10,000 people) where alcohol, opiates, or other drugs were recorded as the primary diagnosis for which services were sought at admission. “Inpatient” refers to a patient whose treatment needs at least one night's residence in a hospital. The substance for which treatment was received was identified through hospital codes (ICD-9 codes) and includes those related to alcohol and psychoactive substances (303-305). More than one substance may be involved in a single visit. The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas.

Operationalized as:  $\left( \frac{\# \text{ of inpatient hospitalizations}}{\text{population}} \right) \times 10,000$

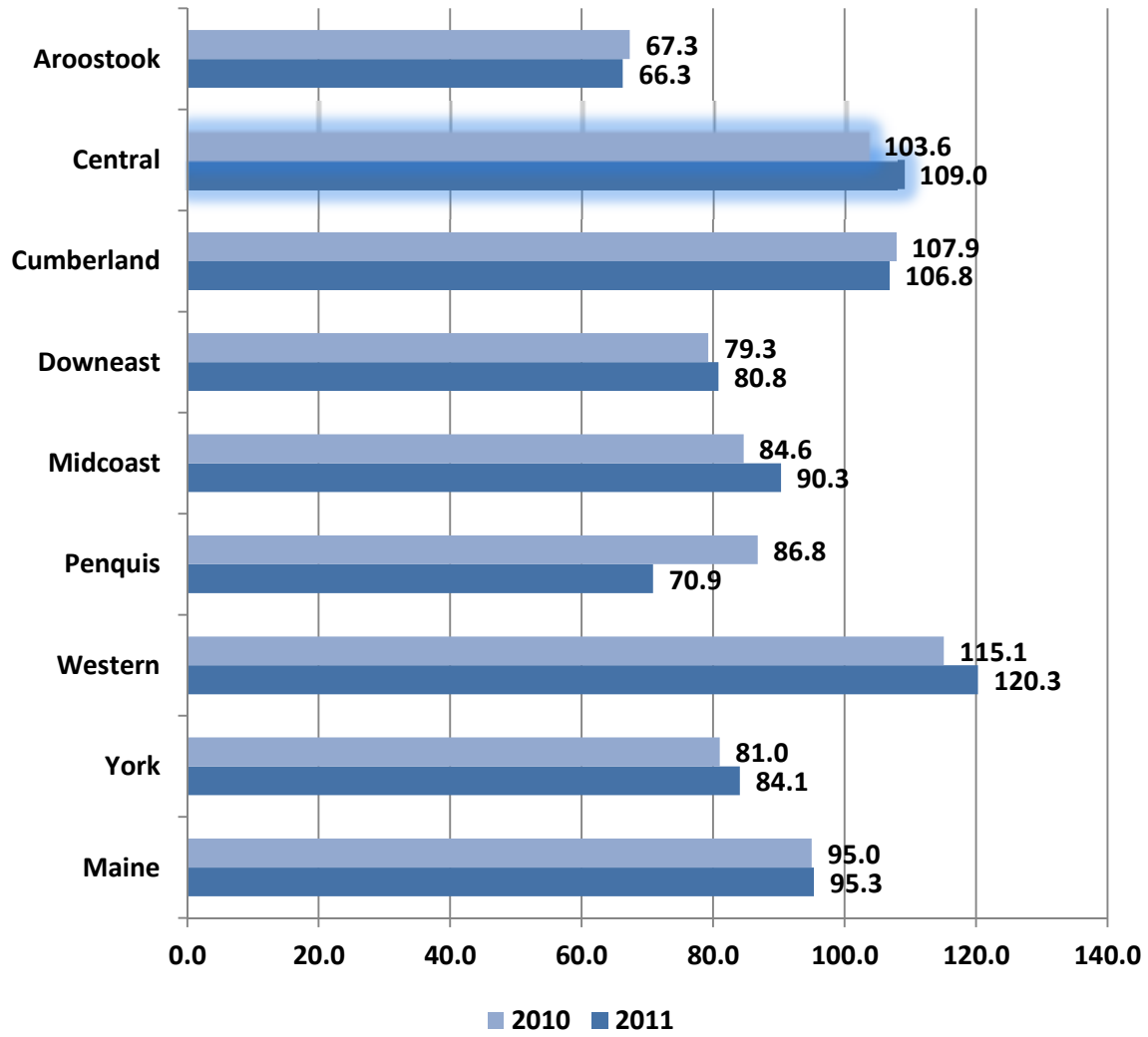
**Why Indicator is Important:** Hospital admissions related to substance use are an indication of injury sustained through substance use and the impact it has on the healthcare system.

**Data Source(s):** MHDO, 2010 and 2011.

**Summary:** The inpatient admissions rate due to substance abuse in Central PHD increased from 2010 (103.6 admissions per 10,000 residents) to 2011 (109 admissions per 10,000). In 2011, Central PHD had a higher inpatient substance use rate compared to the state (95.3 admissions per 10,000) and had the second highest rate among public health districts.



Figure 23. Inpatient hospital admissions (per 10,000 people) related to substance use\*, by Public Health District: 2010, 2011

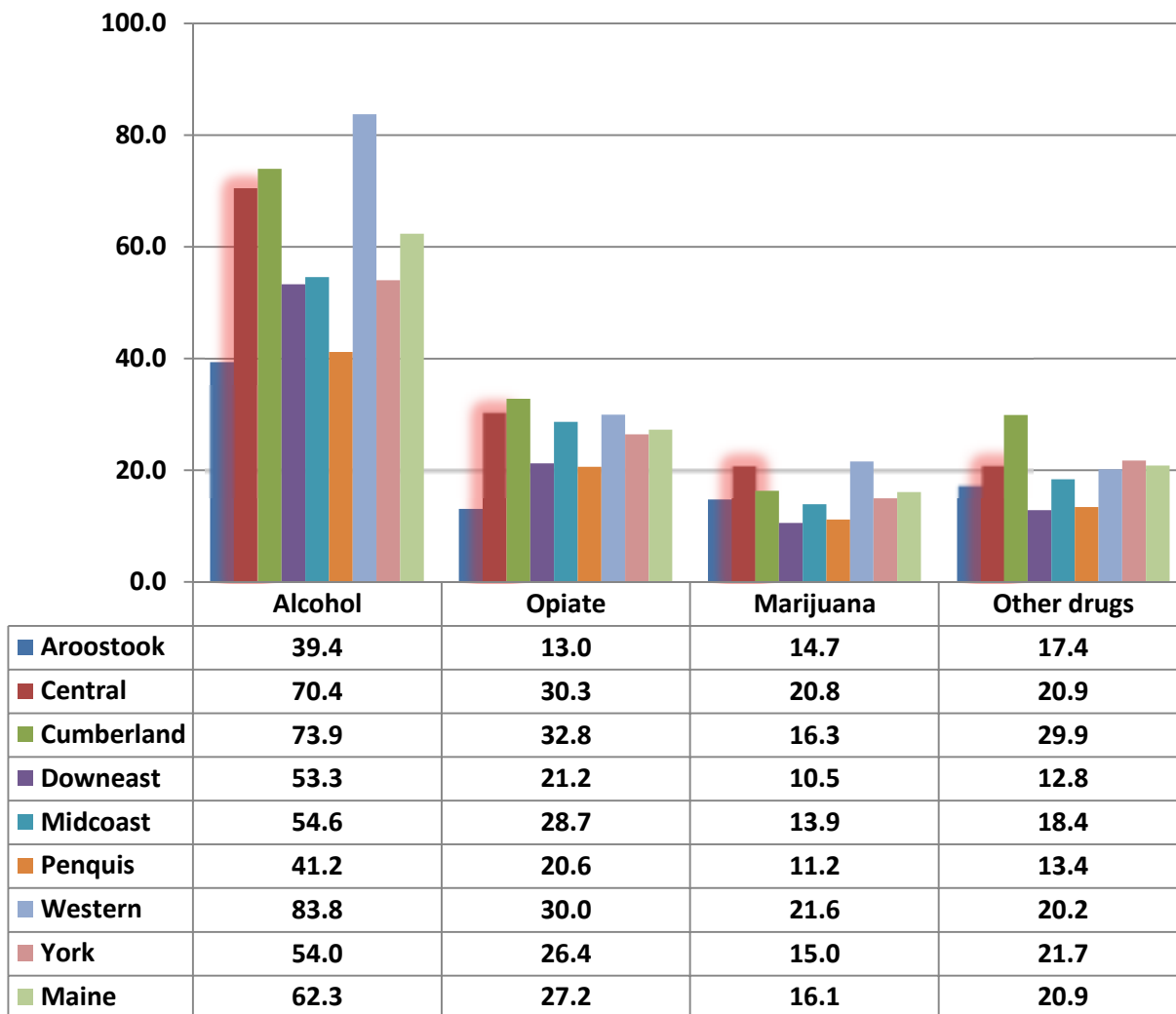


Source: MHDO

\*Visits may involve multiple substances

**Summary:** In 2011, most inpatient admissions due to substance use in Central PHD were related to alcohol (70.4 admissions per 10,000), followed by opiates (30.3 admissions per 10,000), marijuana (20.8 admissions per 10,000), and other drugs (20.9 admissions per 10,000). Among public health districts, Central PHD held the second highest inpatient rate due to opiates, the second highest inpatient rate due to marijuana, and the third highest inpatient rate due to alcohol.

**Figure 24. Inpatient hospital admissions (per 10,000 people) related to substance use\*, by Public Health District and drug type: 2011**



Source: MHDO

\*Visits may involve multiple substances

**Indicator Description: OUTPATIENT HOSPITAL VISITS RELATED TO SUBSTANCE USE.** This indicator shows the number of outpatient hospital admissions (per 10,000 people) where alcohol, opiates, or other drugs was recorded as the primary diagnosis for which services were received. “Outpatient” refers to patients who receive treatment at a hospital or clinic but are not admitted overnight. The substance for which treatment was received was identified through hospital codes (ICD-9 codes) and includes those related to alcohol psychoactive substances (303-305). The rate per 10,000 allows us to see frequency with which an occurrence shows up within a population over time, as well as make relative comparisons between small and large population areas.

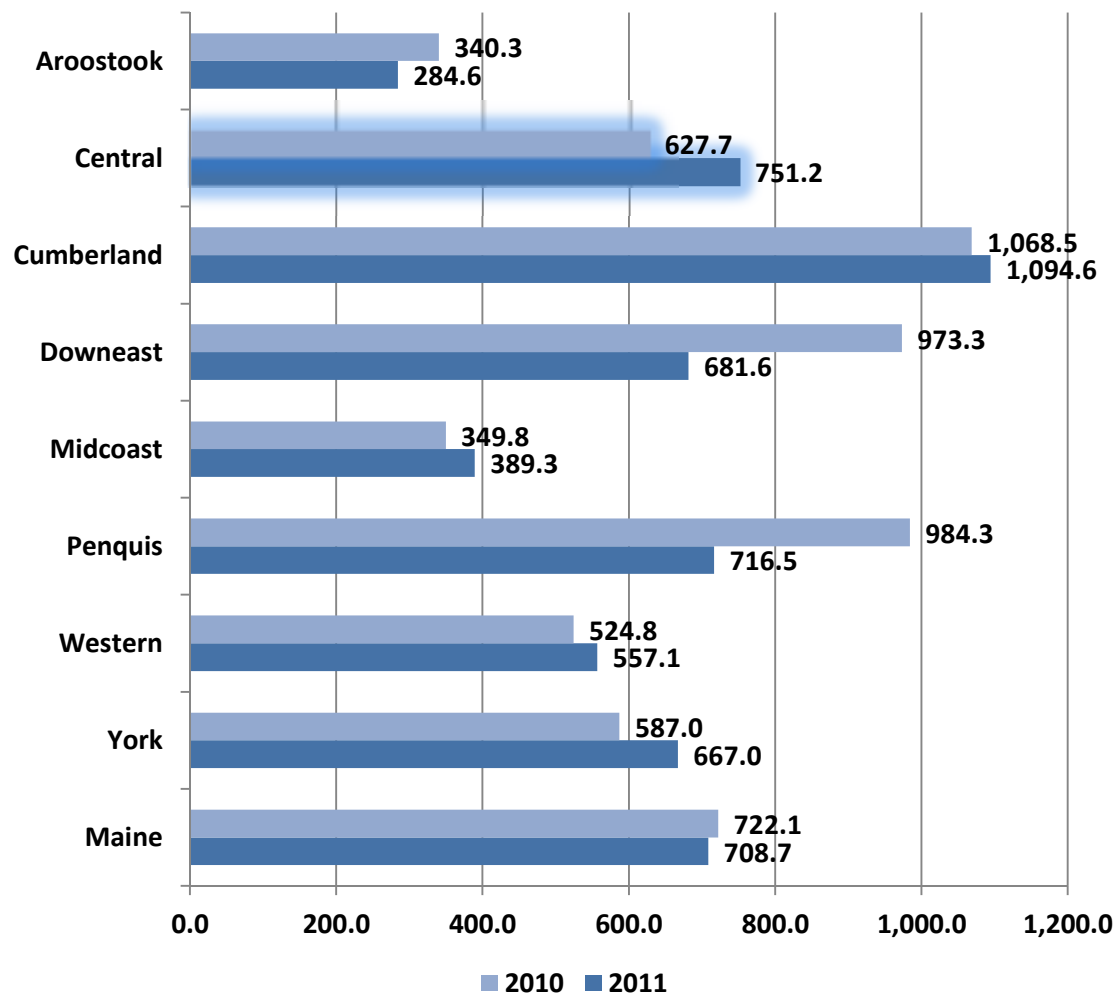
Operationalized as:  $\left( \frac{\# \text{ of outpatient hospitalizations}}{\text{population}} \right) \times 10,000$

**Why Indicator is Important:** Outpatient hospital visits related to substance use are an indication of injury sustained through substance use and the impact it has on the healthcare system.

**Data Source(s):** MHDO, 2010 and 2011

**Summary:** From 2010 to 2011, the outpatient admission rate due to substance use in Central PHD increased substantially from 627.7 admissions per 10,000 residents to 751.2 admissions per 10,000 residents. In 2011, Central PHD had a higher rate than that of the state (708.7 admissions per 10,000) and held the second highest rate among public health districts.

Figure 25. Outpatient hospital admissions (per 10,000 people) related to substance use\*, by Public Health District: 2010, 2011

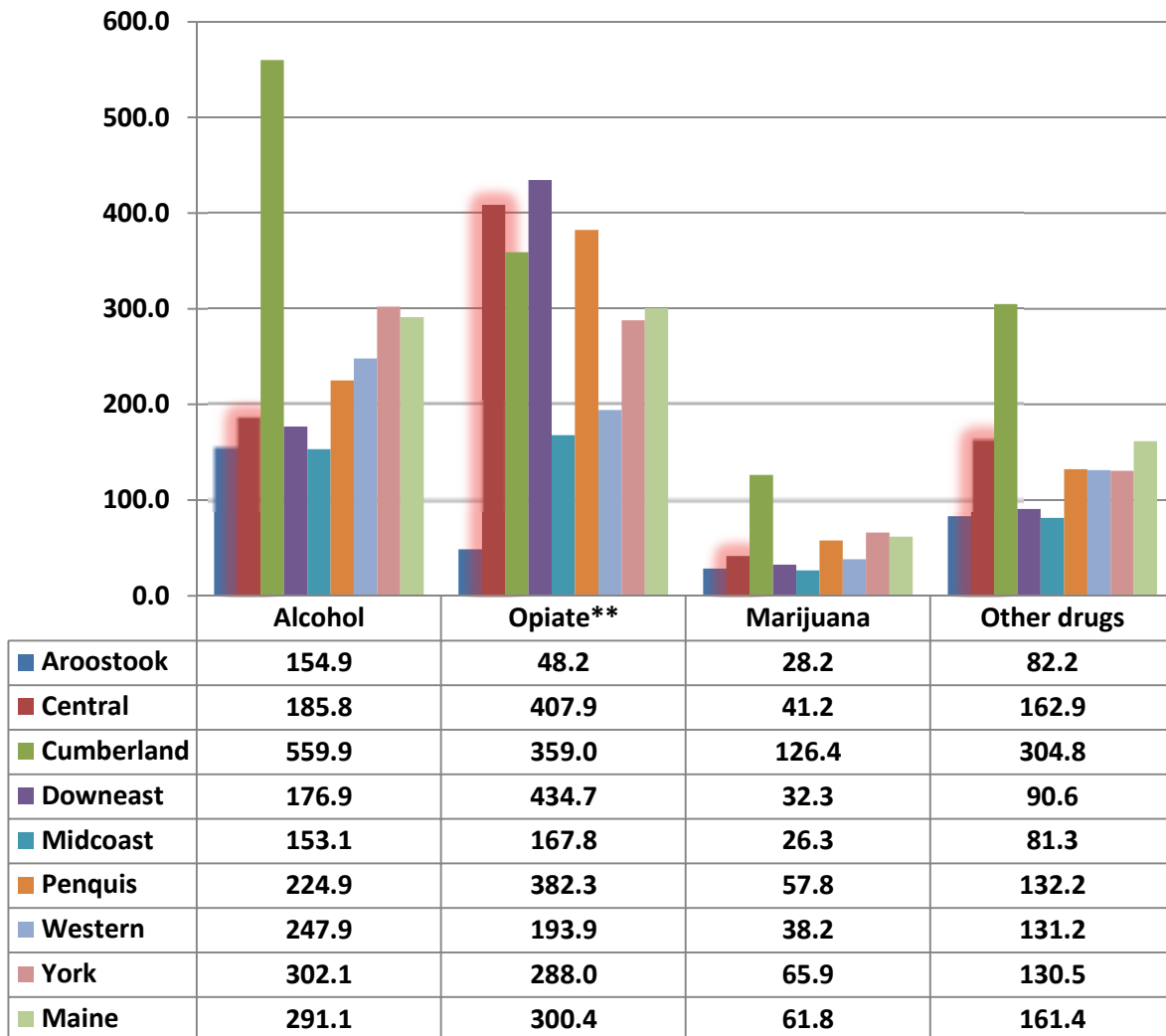


Source: MHDO

\*Visits may involve multiple substances

**Summary:** In 2011, Central PHD had the second highest outpatient admission rate due to opiates among public health districts (407.9 admissions per 10,000); this rate was significantly higher than the statewide rate (300.4 admissions per 10,000). Central PHD had comparatively low rates concerning outpatient admissions due to alcohol (185.8 per 10,000) and marijuana (41.2 per 10,000).

**Figure 26. Outpatient hospital admissions (per 10,000 people) related to substance use\*, by Public Health District and drug type: 2011**



Source: MHDO

\*Visits may involve multiple substances

\*\*Includes prescription narcotics, methadone, and heroin.

## Overdoses and Deaths

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**Indicator Description: OVERDOSES.** This indicator shows the number of persons receiving help from Emergency Medical Services (EMS) related to an overdose in 2011 and 2012.

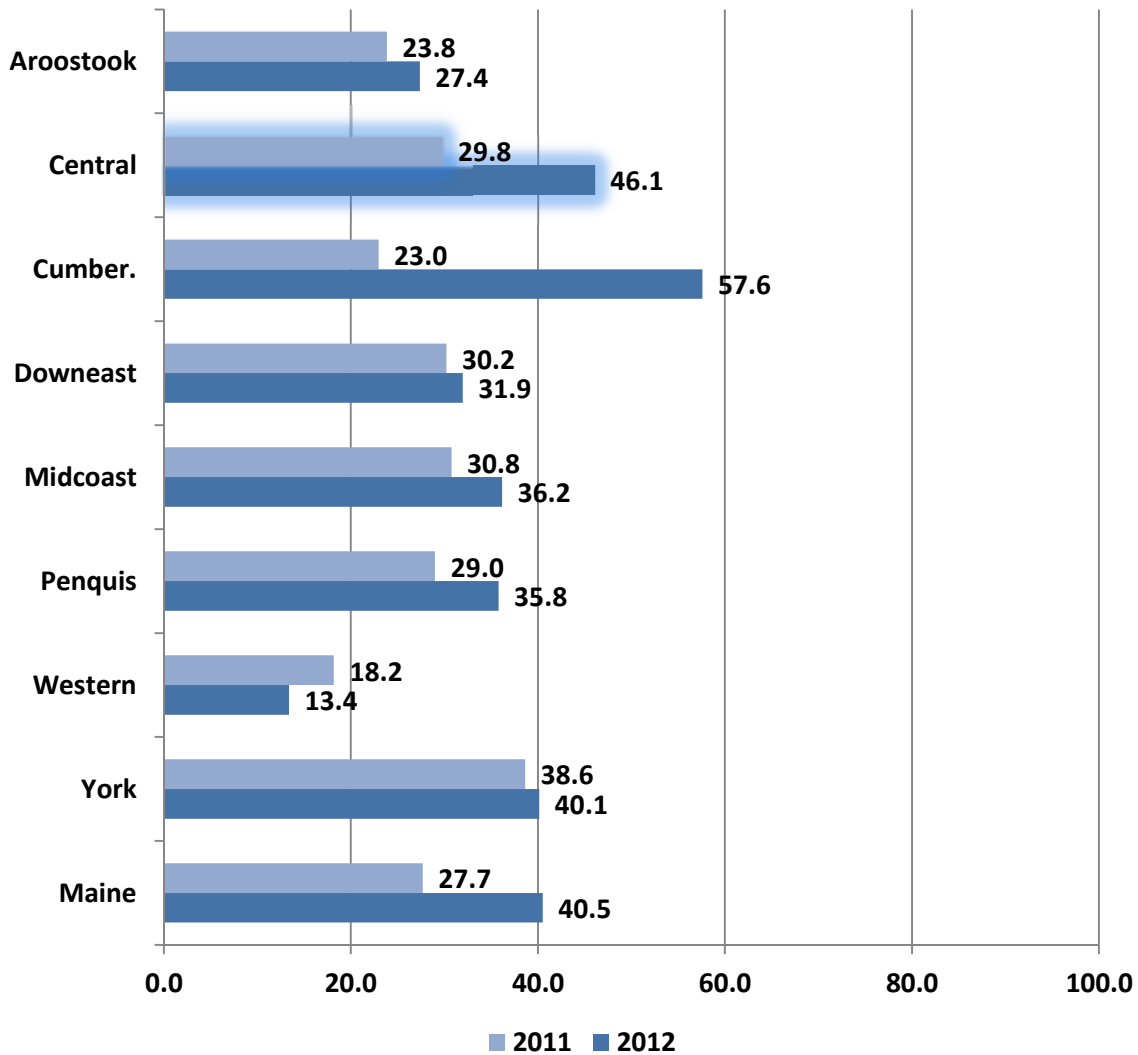
**Why Indicator is Important:** Overdosing on a substance can cause serious physical harm resulting in hospitalization and even death. Responding to overdoses also uses valuable EMS resources. The rate per 10,000 allows us to see the frequency with which an occurrence happens within a population over time, as well as make relative comparisons between small and large population areas. In this case, the base of 10,000 people was used due to small numbers.

Operationalized as:  $\left( \frac{\# \text{ of overdose deaths}}{\text{population}} \right) \times 10,000$

**Data Source(s):** Emergency Medical Services, 2011-2012

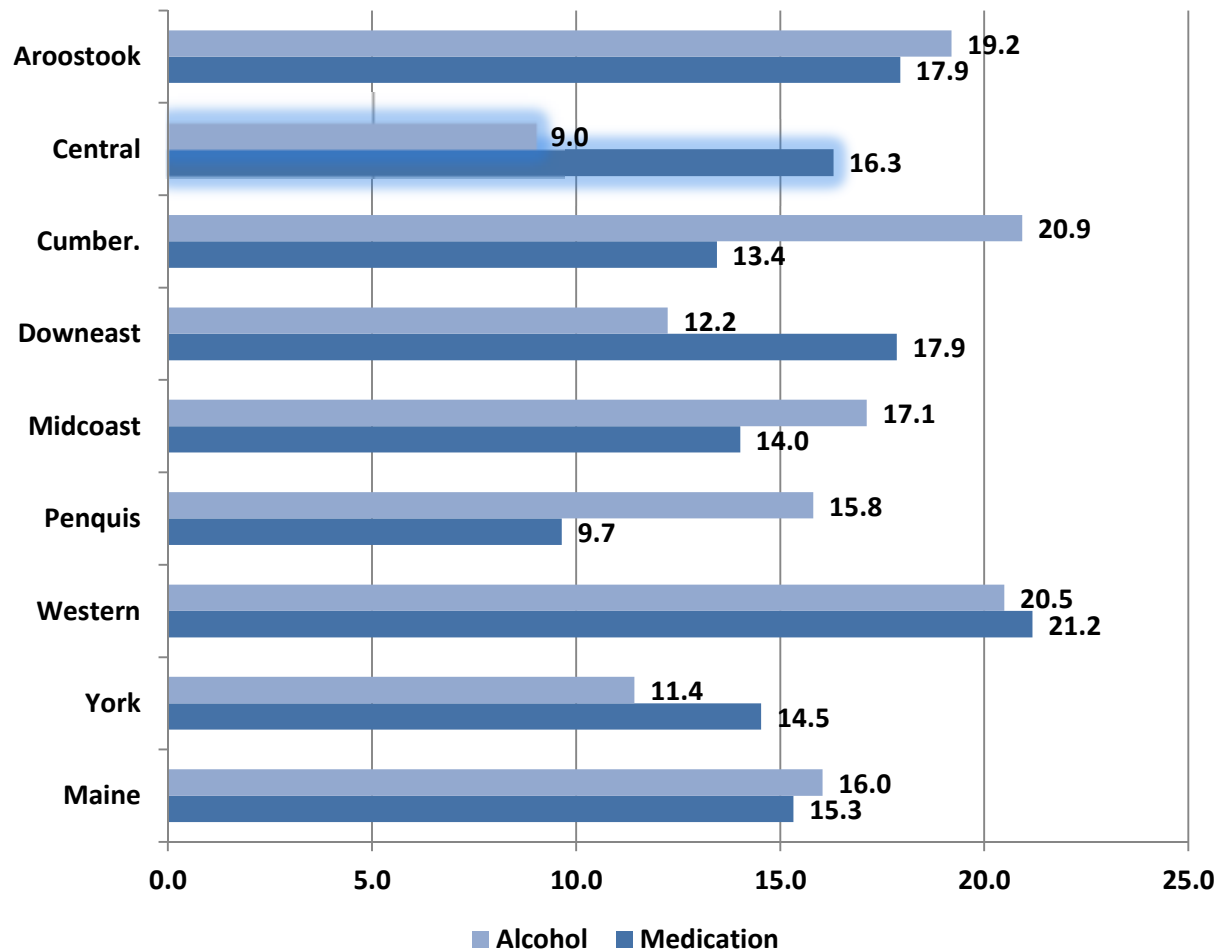
**Summary:** From 2011 to 2012, the Central PHD EMS overdose rate increased from 29.8 overdoses per 10,000 residents to 46.1 overdoses per 10,000 residents; this was higher than the statewide rate (40.5 per 10,000) and the second highest EMS overdose rate among all Maine public health districts. When examined by primary type of substance involved, medication had the highest rate with 16.3 overdoses per 10,000 residents, followed by alcohol with 9.0 overdoses per 10,000 residents.

Figure 27. Number of overdoses per 10,000 residents, by  
Public Health District: 2011 and 2012



Source: Emergency Medical Services, 2011 and 2012

Figure 28. Number of overdoses per 10,000 residents, by  
Public Health District and primary type of substance  
involved: 2012



Source: Emergency Medical Services, 2012



**Indicator Description: DEATHS DUE TO OVERDOSE.** This measure reflects the number of deaths where the cause of death was directly related to the consumption of one or more substances. The measure excludes deaths where a substance may have been ingested prior to engaging in a behavior that resulted in death (e.g., drunk driving) or where lifetime substance use and abuse may have impacted health (e.g., cirrhosis). In order to preserve anonymity and strengthen validity, rates were calculated based on the sum of deaths per three year intervals. The rate per 100,000 allows us to see the frequency with which an occurrence happens within a population over time, as well as make relative comparisons between small and large population areas. In this case, the base of 100,000 people was used due to small numbers.

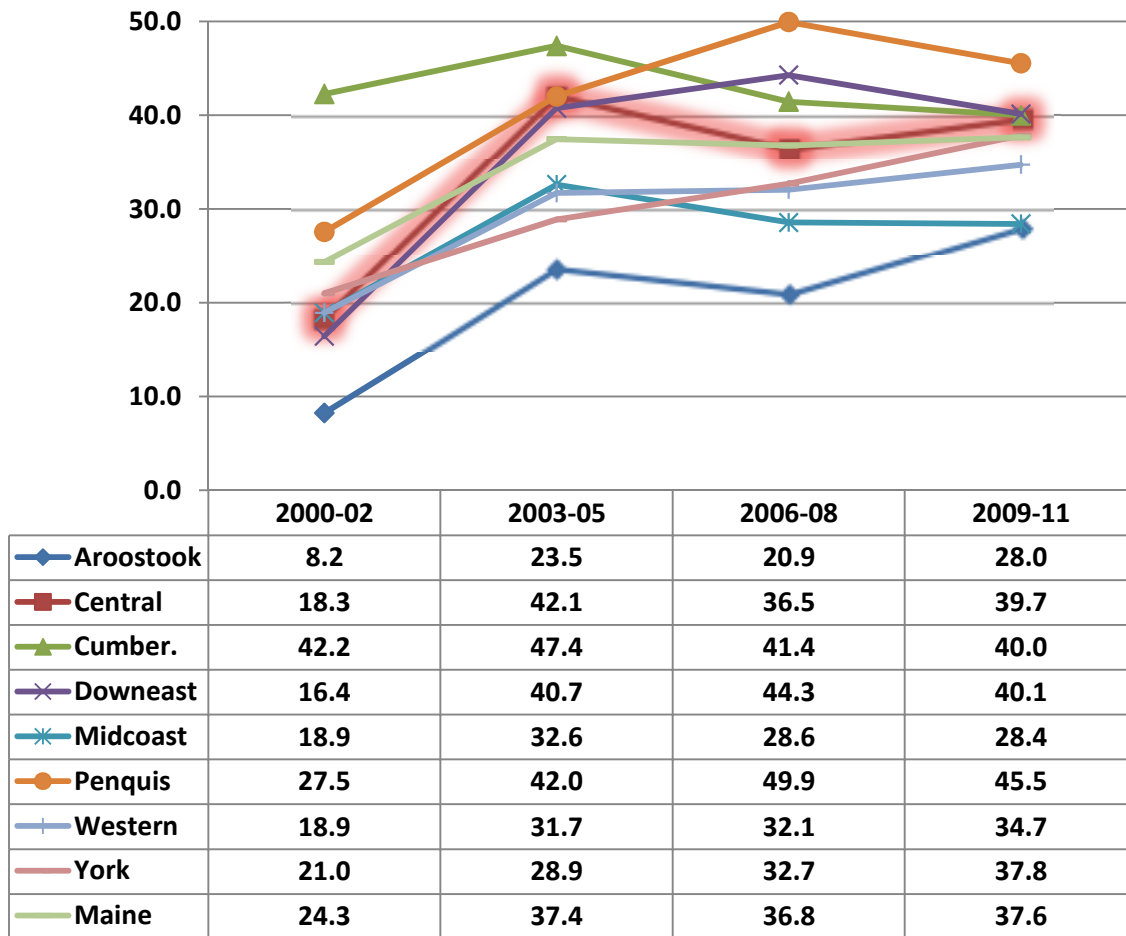
Operationalized as:  $\left( \frac{\# \text{ of overdose deaths}}{\text{population}} \right) \times 100,000$

**Why Indicator is Important:** One of the most extreme consequences of alcohol and drug abuse is overdose death; that is, the substance(s) consumed played a direct role in an individual's death. These are seen as potentially preventable deaths.

**Data Source(s):** Office of Chief Medical Examiner, 2000-02 to 2009-11.

**Summary:** Between years 2009 and 2011, the drug overdose death rate in Central PHD was 39.7 per 100,000; this rate was higher than that of the state (37.6 per 10,000) and has more than doubled since the 2000-02 period (18.3 per 10,000).

Figure 29. Drug-related death rate per 100,000, by Public Health District: 2000-02 to 2009-11



Source: Office of the Chief Medical Examiner.

## Factors Contributing to Substance Use and Abuse

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A body of substance abuse prevention research has identified certain groups of factors that “cause” or have an impact on substance use and the consequences related to use. That is, they appear to influence the occurrence and magnitude of substance use and its related consequences. Generically, these causal factors (also known as contributing factors) are categorized into groups which include:

- Social Access (e.g., getting drugs and alcohol from friends or family)
- Retail Availability (e.g., retailer not carding properly)
- Pricing & Promotion (e.g., two-for-one specials, industry sponsorships or signage)
- Social/Community Norms (e.g., parental/community attitudes and beliefs)
- Enforcement (e.g., lack of compliance checks)
- Perceptions of Harm (e.g., individuals’ belief that using a substance is harmful)<sup>3</sup>
- Perceived Risk of Being Caught (e.g., individuals’ belief that s/he will be caught by parents or police)<sup>4</sup>

Substance abuse prevention in Maine is undertaken with the assumption that making changes to these factors at the community level will result in changing behaviors around substance use and related problems. It is through positively impacting these factors that Maine can achieve population-level changes in substance consumption and consequences.

In Central PHD, the dispensed quantity per capita rate for narcotics is higher than the statewide rate and comparatively high when compared to other public health districts. However, the liquor licensee rate in Central PHD has remained relatively low.

Although most high school students in Central PHD believe that regular use of marijuana poses a risk of harm, less than a third think they will be caught by police if they use marijuana. Most students in Central PHD think it is easy to obtain alcohol, with forty five percent believing they would be caught by their parents and only 16 percent believing they would be caught by police if they drank alcohol.

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<sup>3</sup> Bonnie, Richard J., and Mary Ellen O’Connell, Eds. (2004). *Reducing Underage Drinking: A Collective Responsibility*. The National Academies Press: Washington, DC.

<sup>4</sup> “A General Causal Model to Guide Alcohol, Tobacco and Illicit Drug Prevention: Assessing the Research Evidence.” Multi-State Technical Assistance Workshop. Washington, DC. March 16, 2006.



## Availability and Accessibility

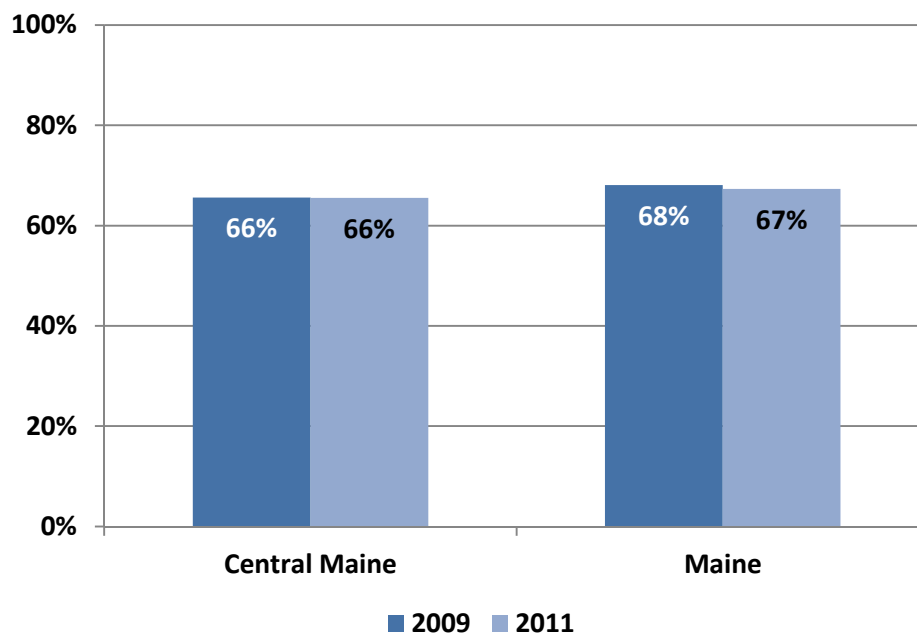
**Indicator Description: PERCEIVED EASE OF OBTAINING ALCOHOL BY UNDERAGE YOUTH.** This indicator reflects the percentage of high school students (grades 9 to 12) who reported that it would be easy or very easy for them to get alcohol if they wanted some.

**Why Indicator is Important:** According to the 2011 statewide MIYHS, students who reported that they thought alcohol was easy to obtain were three times as likely to report consuming alcohol within the past month compared to students who did not think it was easy obtain.

**Data Source(s):** MIYHS, 2009-2011.

**Summary:** In 2011, 66 percent of high school students in Central PHD indicated that it was easy to get alcohol, slightly lower than the statewide rate of 67 percent.

**Figure 30. Percent of high school students in Central PHD who reported it was easy to get alcohol: 2009, 2011**



Source: MIYHS

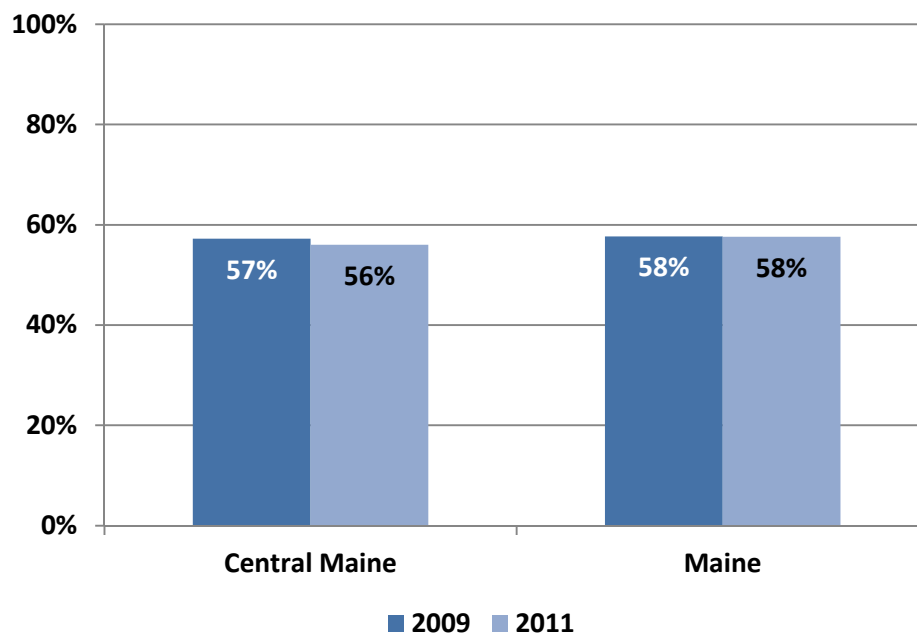
**Indicator Description: PERCEIVED EASE OF OBTAINING MARIJUANA BY YOUTH.** This indicator illustrates the percentage of high school students reporting it would be easy or very easy to obtain marijuana if they wanted it.

**Why Indicator is Important:** According to the 2011 statewide MIYHS, students who reported that they thought marijuana was easy to obtain were seven times as likely to use marijuana in the past 30 days compared to their peers who thought it was difficult to obtain.

**Data Source(s):** MIYHS, 2009-2011.

**Summary:** In 2011, 56 percent of high school students in Central PHD indicated that it would be easy to get marijuana; the statewide average was slightly higher than that, at 58 percent.

**Figure 31. Percent of high school students in Central PHD who reported it would be easy to get marijuana: 2009, 2011**



Source: MIYHS

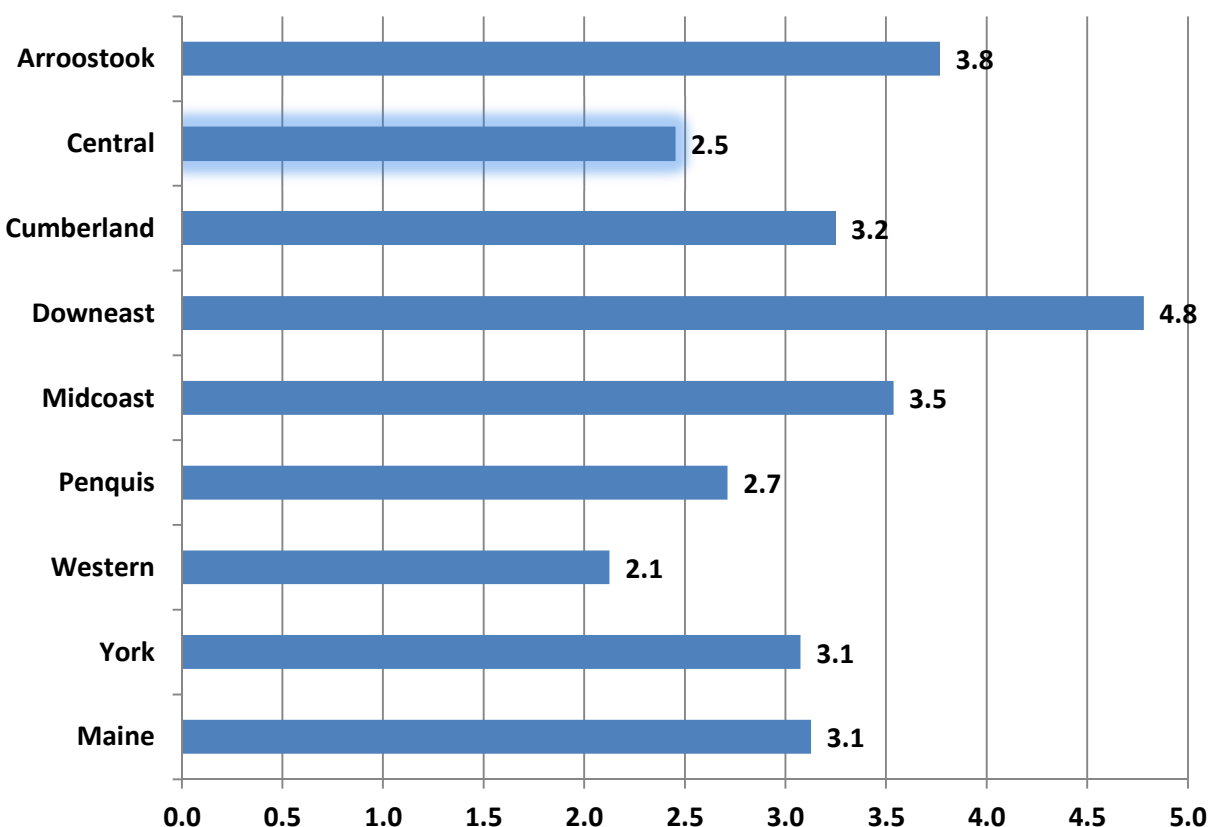
**Indicator Description: NUMBER OF ALCOHOL OUTLETS PER CAPITA.** This indicator reflects the number of active (as of May 2013) retail establishments selling alcohol per person. This includes both on-premise (e.g., bars, restaurants) and off-premise (e.g., convenience stores) establishments. It is calculated by dividing the number of active retail establishments by the number of residents in the county (based on 2012 U.S. Census estimates).

**Why Indicator is Important:** National research shows that there is a correlation between the number of places that sell alcohol in an area (retail density) and the rate of alcohol-related crime.<sup>5</sup>

**Data Source(s):** DPS, Liquor Licensing and Compliance, 2013; U.S. Census, 2010.

**Summary:** The number of liquor licensees in Central PHD per 1,000 residents (2.5) was noticeably lower than the statewide average in 2013 (3.1).

**Figure 32. Number of liquor licensees per 1,000 residents, by Public Health District: 2013**



Source: DPS and U.S. Census

<sup>5</sup>Grube, J. W., Gruenewald, P. J. & Chen, M. J. (2010). Community alcohol outlet density and underage drinking. *Addiction*, 105, 270-278.

**Indicator Description: DISPENSED QUANTITY OF SCHEDULE II DRUGS PER CAPITA.** These indicators reflect the dispensed quantity of narcotics, tranquilizers, and stimulants through prescriptions in Maine. This includes only prescription drugs that are classified “Schedule II” drugs, meaning those with a high potential for abuse. It is important to note that the dispensed quantity does not indicate the size or dosage of the pills associated with the prescription. All pharmacies in Maine report to the Prescription Monitoring Program.

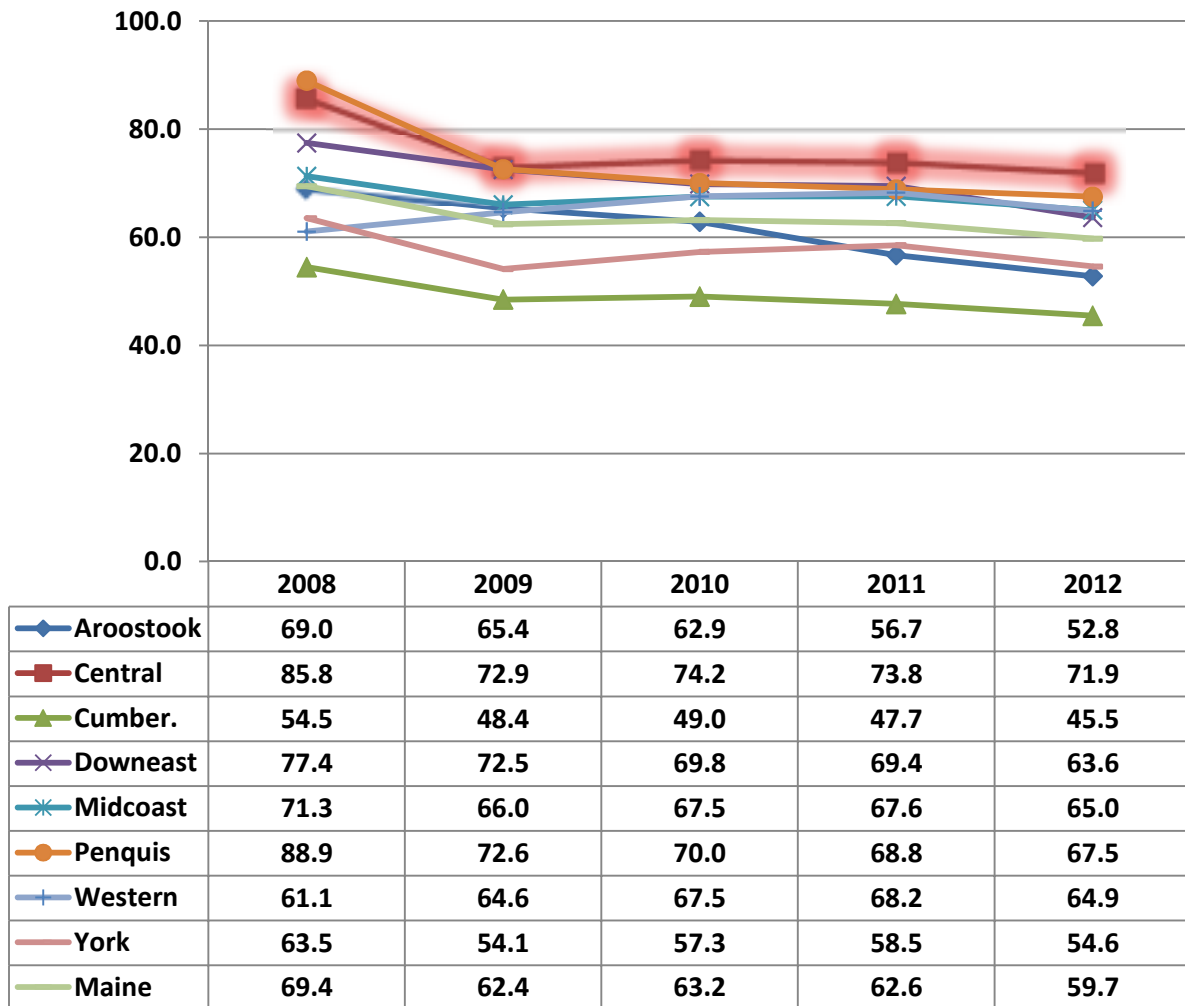
**Why Indicator is Important:** The dispensed quantity per capita indicates the volume of prescription drugs potentially available in the community for diversion (e.g., gift, sale, or theft). A higher level of availability contributes to misuse by individuals without a prescription.

**Data Source(s):** PMP, 2008-2012

**Summary:** The dispensed quantity of narcotics per capita in Central PHD decreased in 2009 and then remained relatively stable. Since that time, Central PHD has the highest rate among public health districts. In 2012, Central PHD had a quantity dispensed rate of 71.9 per person; this was notably higher than the statewide rate (59.7 per person).



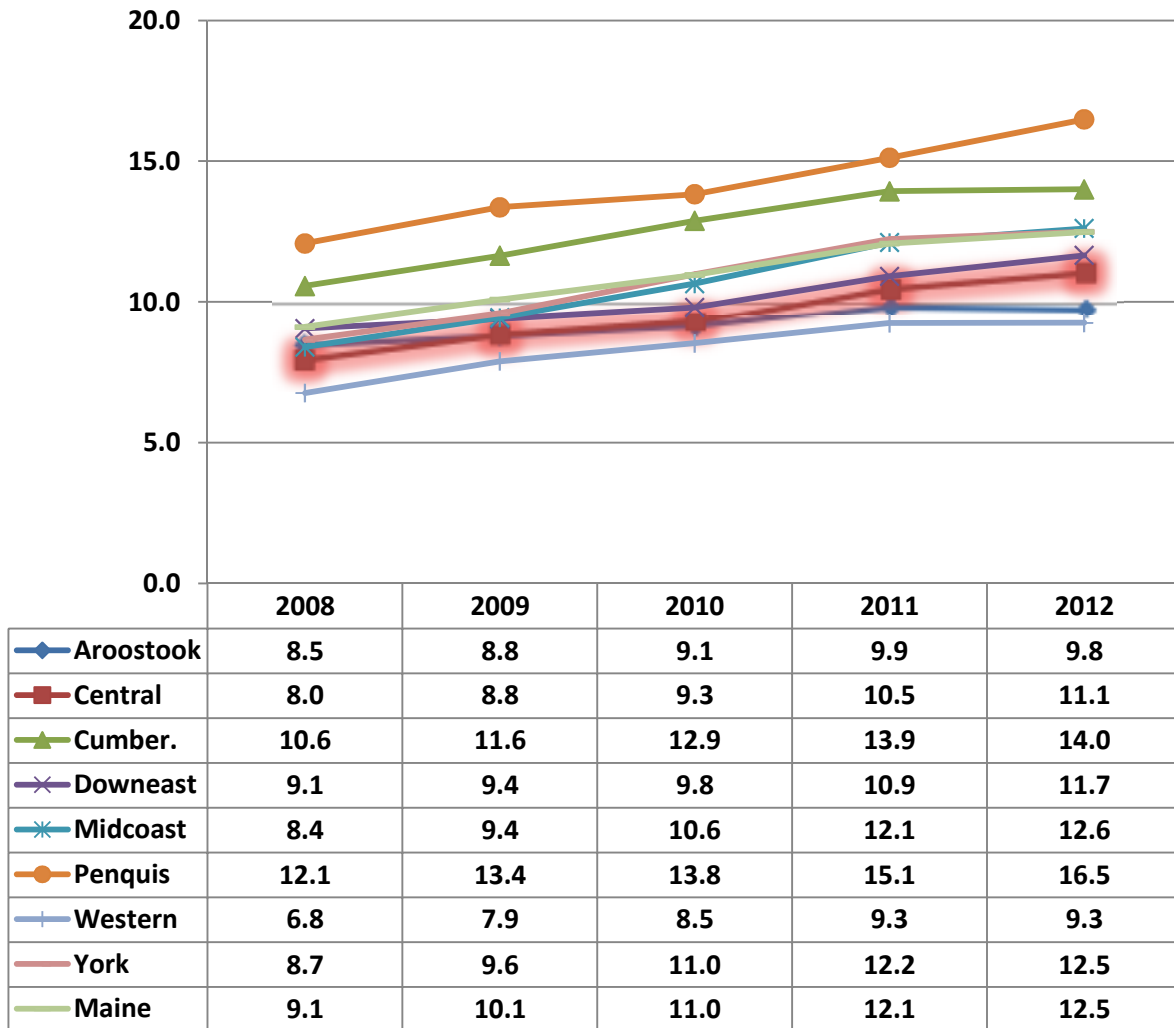
Figure 33. Dispensed quantity of narcotics per capita, by  
Public Health District: 2008-2012



Source: PMP, 2006-2012

**Summary:** The dispensed quantity of stimulants per capita in Central has steadily increased from 8 per person in 2008 to 11.1 per person in 2012; this was lower than the statewide rate (12.5 per person) and third lowest among public health districts.

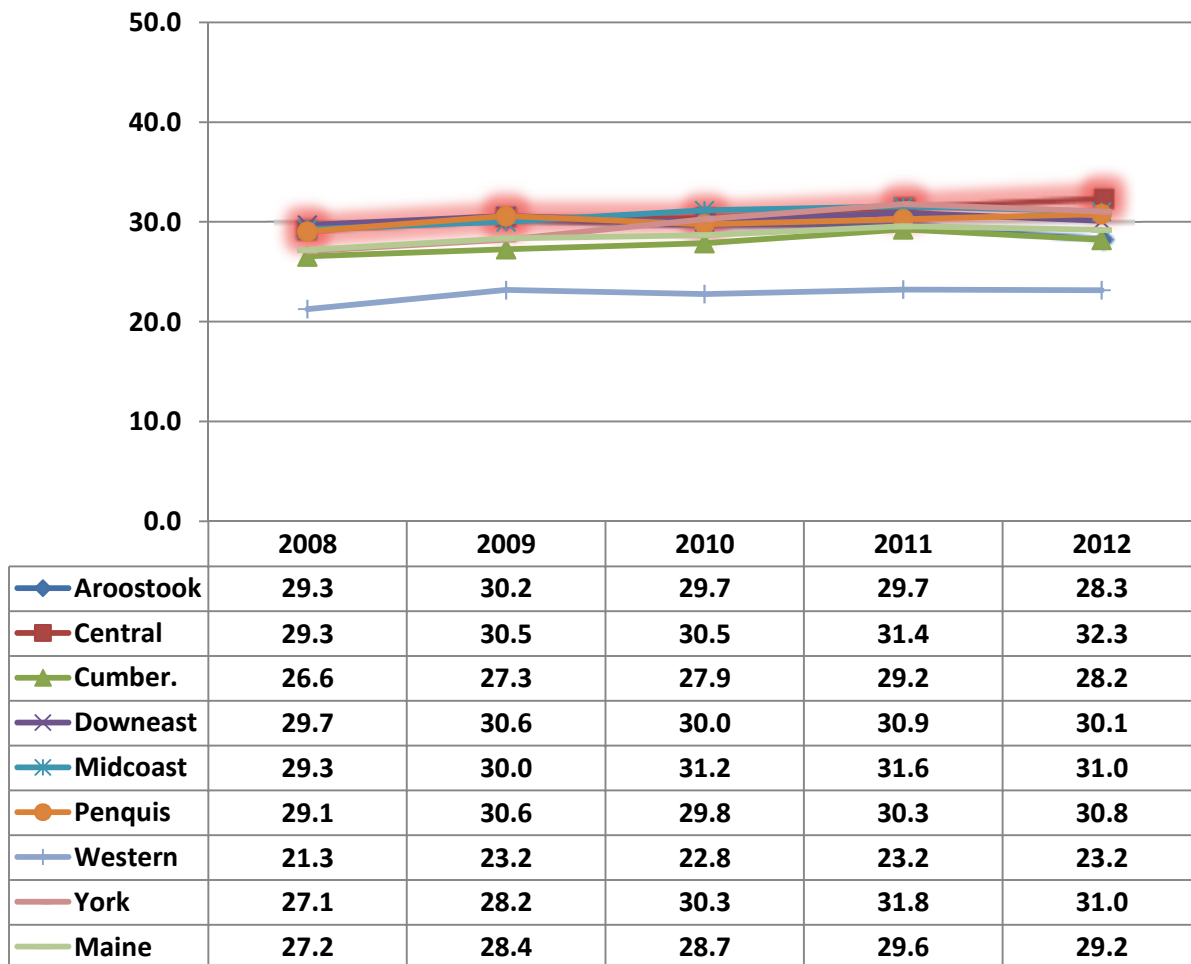
**Figure 34. Dispensed quantity of stimulants per capita, by Public Health District: 2008-2012**



Source: PMP, 2008-2012

**Summary:** The dispensed quantity of tranquilizers per capita in Central PHD increased slightly from 29.3 in 2008 to 32.3 in 2012; this was higher than the statewide rate (29.2 per person) and highest among public health districts. Most public health districts' rates, including Central PHD, have remained relatively stable and on par with the statewide average over the past five years shown.

**Figure 35. Dispensed quantity of tranquilizers per capita, by  
Public Health District: 2008-2012**



Source: PMP, 2008-2012

## Perceived Risk and Harm

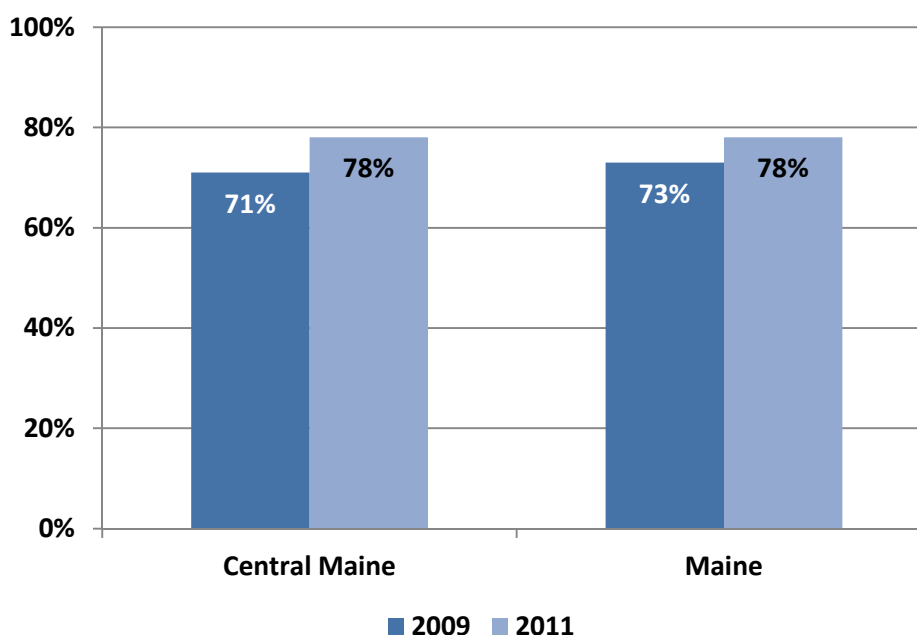
**Indicator Description: PERCEIVED RISK FROM BINGE DRINKING AMONG YOUTH.** This indicator reflects the percentage of individuals who perceive that there is moderate-to-great risk from drinking five or more drinks once or twice per week.

**Why Indicator is Important:** According to the 2011 statewide MIYHS, high school students who perceive binge drinking as a moderate-to-great risk of harm are one-third as likely to binge drink in the past month than students who did not perceive harm. Adults are also less likely to binge drink if they perceive it to be risky.

**Data Source(s):** MIYHS, 2009-2011.

**Summary:** From 2009 to 2011, the percentage of high school students in Central PHD who indicated that there is a moderate-to-great risk of people harming themselves if they consume five or more drinks regularly increased from 71 percent to 78 percent, with the latest figures matching the state average.

**Figure 36. Percent of high school students in Central PHD who reported a risk of harm from consuming five or more drinks once or twice per week: 2009, 2011**



Source: MIYHS

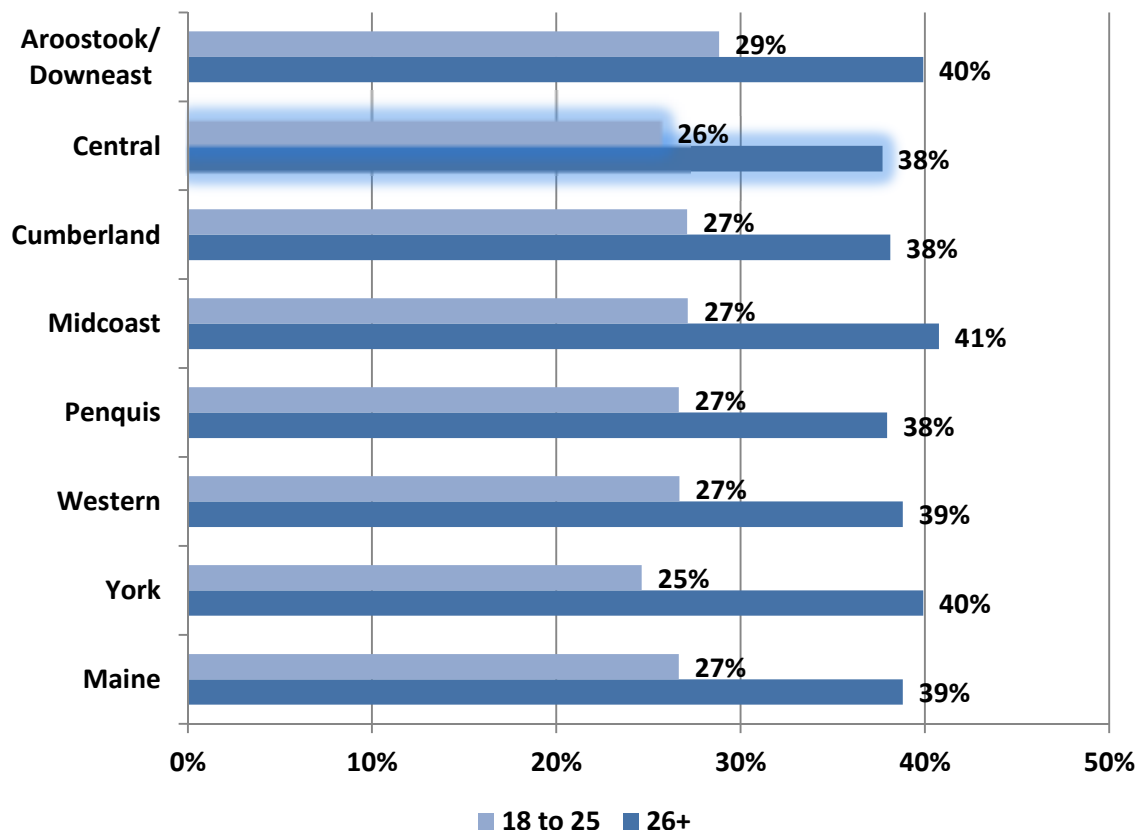
**Indicator Description: PERCEIVED RISK FROM BINGE DRINKING AMONG MAINERS.** This indicator reflects the percentage of Mainers age 18 and older who perceive that there is risk from consuming five or more drinks once or twice per week. Because of small sample sizes, survey data from multiple years must be combined in order to produce this estimate.

**Why Indicator is Important:** The perception that consuming a lot of alcohol is risky indicates an individual is knowledgeable about health risks and other negative consequences. Adults are less likely to binge drink if they perceive it to be risky.

**Data Source(s):** NSDUH, 2008-10.

**Summary:** During the period 2008-10, 26 percent of Central PHD residents ages 18-25 indicated perceived risk from binge drinking, compared to 38 percent among those 26 and older. Although not shown, rates of perception of risk from binge drinking among Central PHD residents 12 and older decreased from 2006-08 (38%) to 2008-10 (36%).

**Figure 37. Percent of population age 18 or older who perceive a great risk from binge drinking, by Public Health District: 2008-10**



Source: NSDUH

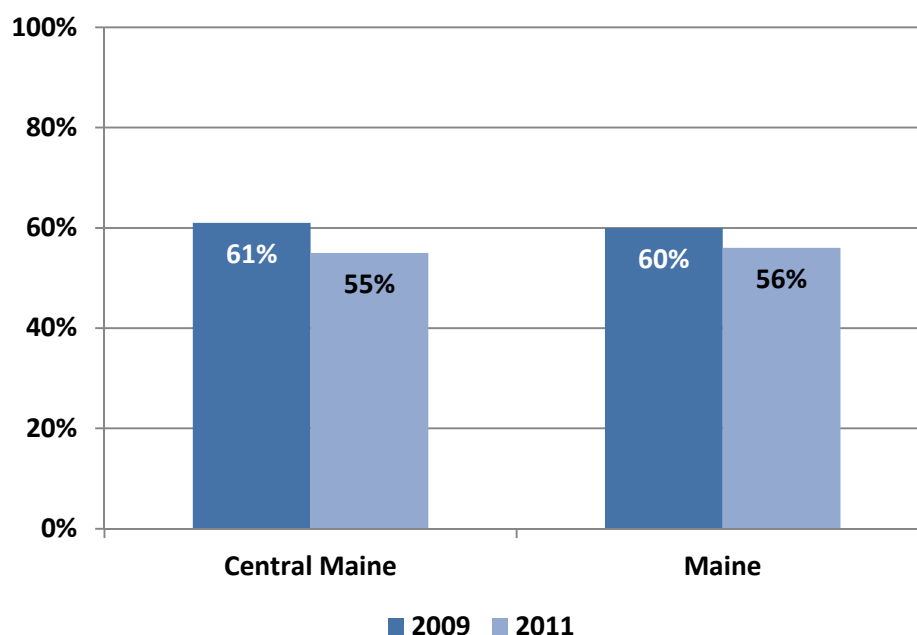
**Indicator Description: PERCEIVED RISK OF MARIJUANA USE AMONG YOUTH.** This measure demonstrates the percentage of individuals who perceive a moderate-to-great risk of harm from smoking marijuana regularly.

**Why Indicator is Important:** According to the 2011 statewide MIYHS, high school students who do not believe there is moderate-to-great risk in smoking marijuana regularly are 6.5 times as likely to smoke marijuana as their peers who do perceive risk of harm.

**Data Source(s):** MIYHS, 2009-2011.

**Summary:** From 2009 to 2011, the percentage of high school students in Central PHD who indicated that there is a moderate-to-great risk of people harming themselves if they smoke marijuana regularly decreased significantly, from 61 percent to 55 percent. This was similar to the state average (56%).

**Figure 38. Percent of high school students in Central PHD who reported a risk of harm from smoking marijuana regularly: 2009, 2011**



Source: MIYHS

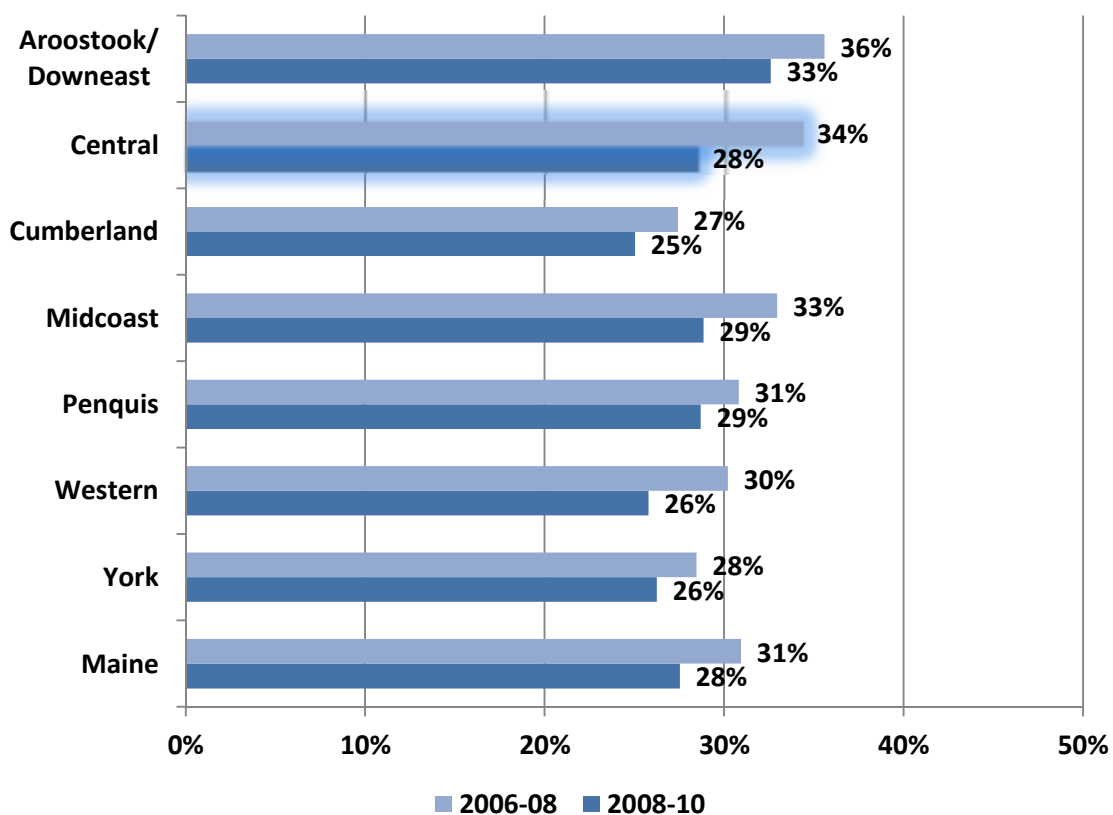
**Indicator Description: PERCEIVED RISK OF MARIJUANA USE AMONG MAINERS.** This measure demonstrates the percentage of Mainers over the age of 12 who perceive a risk of harm from smoking marijuana once a month. Because of small sample sizes, survey data from multiple years must be combined in order to produce this estimate.

**Why Indicator is Important:** The perception that using a substance is risky indicates an individual is knowledgeable about health risks and other negative consequences associated with that substance. Perceptions of risk reduce the likelihood that an individual will engage in the behavior.

**Data Source(s):** NSDUH, 2006-08 and 2008-10.

**Summary:** From 2006-08 to 2008-10, the percentage of Central PHD residents 12 and older who perceived a great risk from smoking marijuana once a month decreased considerably from 34 percent to 28 percent. Perception of risk from marijuana use decreased among all public health districts from 2006-08 to 2008-10.

**Figure 39. Percent of population age 12 or older who perceive a great risk from smoking marijuana once a month, by Public Health District: 2006-2008 and 2008-10**



Source: NSDUH

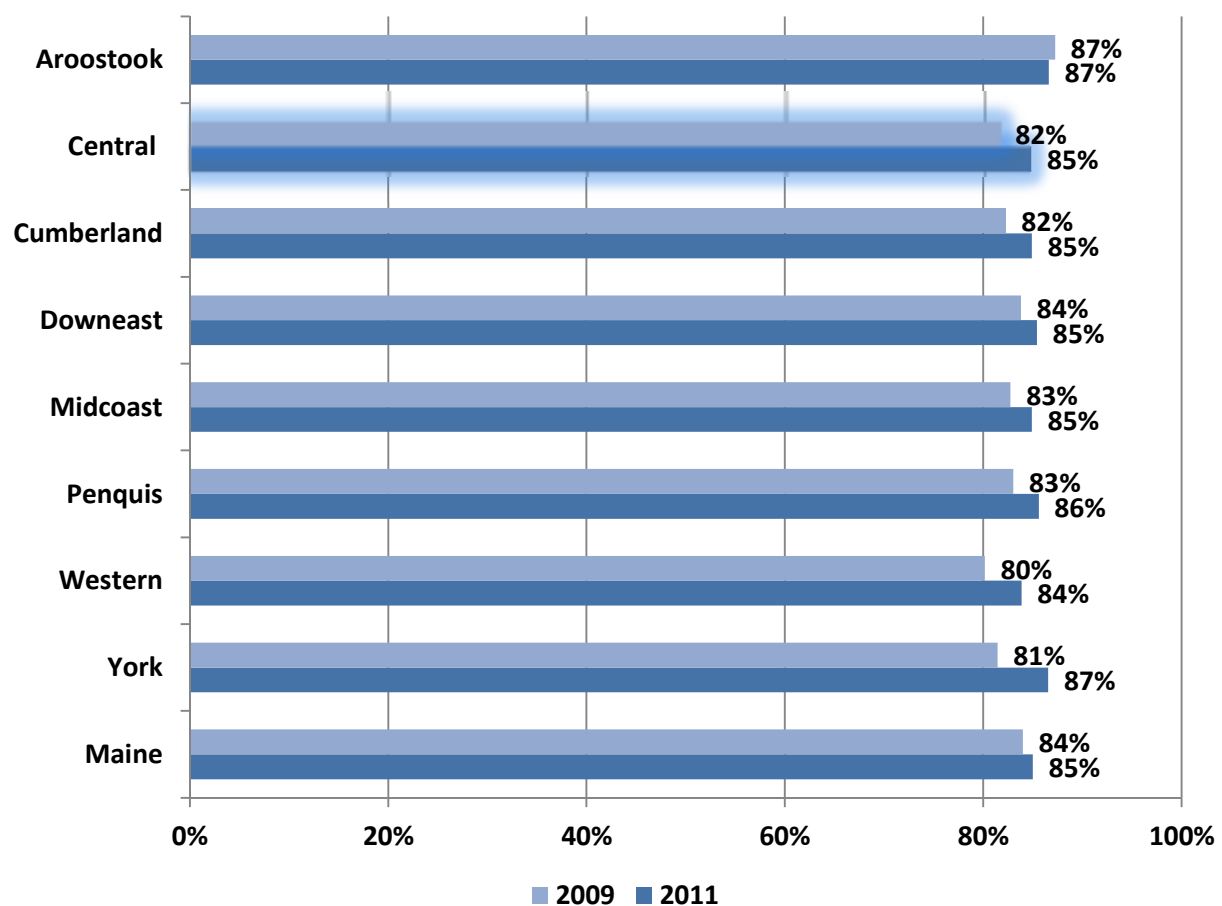
**Indicator Description: PERCEIVED RISK OF PRESCRIPTION DRUG MISUSE AMONG YOUTH.** This measure demonstrates the percentage of individuals who perceive a moderate-to-great risk of harm from taking a prescription drug that was not prescribed to them.

**Why Indicator is Important:** According to the 2011 statewide MIYHS, high school students who do not believe there is moderate-to-great risk misusing prescription drugs are 4.6 times as likely to smoke marijuana as their peers who do perceive risk of harm.

**Data Source(s):** MIYHS, 2009-2011.

**Summary:** Perception of risk from misusing prescription drugs among high school students in Central PHD increased from 82 percent in 2009 to 85 percent in 2011; this was on par with the statewide average. That means 15 percent of students did not think misusing prescription drugs was risky.

**Figure 40. Percent of high school students who reported a risk of harm from misusing prescription drugs, by Public Health District: 2009, 2011**



Source: MIYHS



## Perceived Enforcement

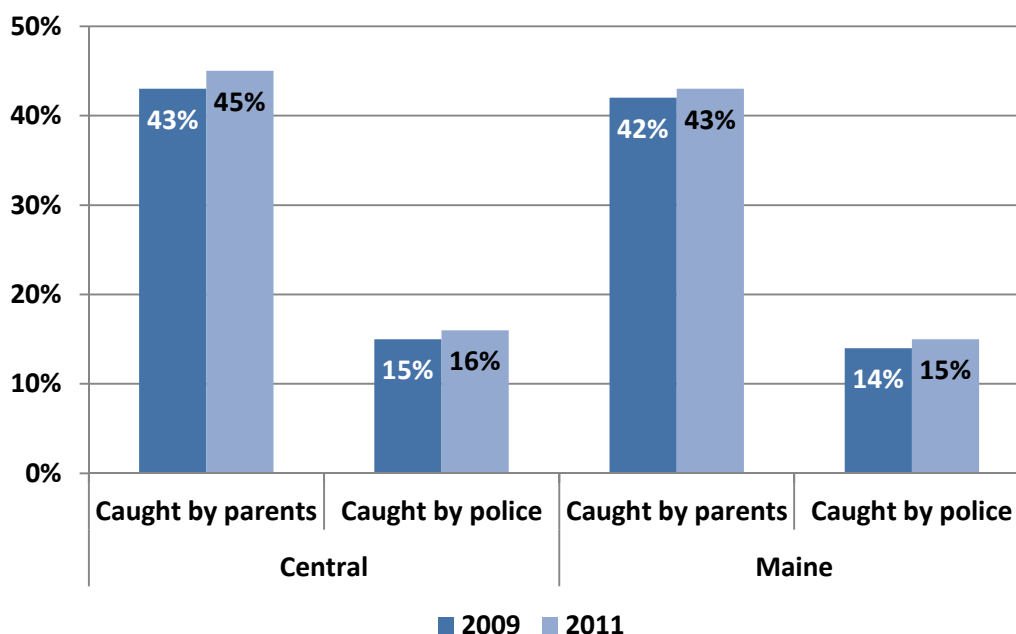
**Indicator Description: PERCIEVED RISK OF BEING CAUGHT FOR DRINKING ALCOHOL AMONG YOUTH.** This indicator reflects the percentage of high school students who reported that they would be caught by their parents or by police if they drank alcohol.

**Why Indicator is important:** According to the 2011 statewide MIYHS, high school students who believe they will be caught by their parents are one-fifth as likely to drink in the past month as compared to students who do not think they will be caught. Students who believe that they would be caught by the police are half as likely to drink alcohol in the past month as those who do not think they would be caught.

**Data Source(s):** MIYHS, 2009-2011.

**Summary:** At 45 percent, the perceived risk among high school students of being caught by their parents for drinking alcohol in Central PHD is greater than the state average (43%). Only 16 percent of high school students indicated that they thought they would be caught by the police for drinking alcohol (compared to 15% statewide who reported that perception). That means high school students in Central PHD are almost three times as likely to perceive a risk of being caught by their parents, rather than the police, for drinking alcohol.

**Figure 41. Perceived risk among high school students in Central PHD of being caught by parents or police for drinking alcohol: 2009, 2011**



Source: MIYHS

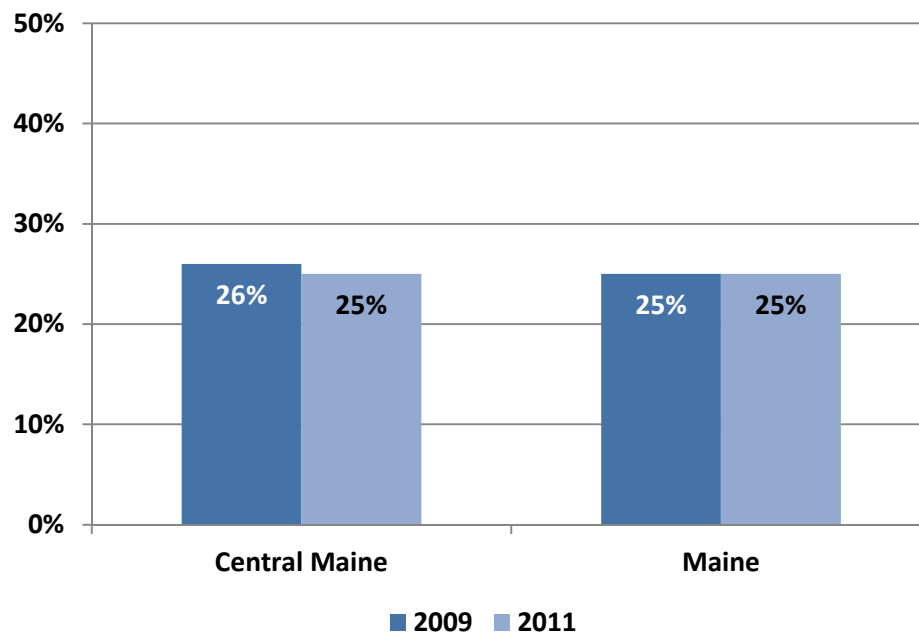
**Indicator Description: PERCEIVED RISK OF BEING CAUGHT FOR SMOKING MARIJUANA AMONG YOUTH.** This measure shows the percentage of high school students who reported that they thought they would be caught by police if they smoked marijuana.

**Why Indicator is Important:** According to the statewide 2011 MIYHS, high school students who believe they would be caught by the police are approximately half as likely to smoke marijuana as their peers.

**Data Source(s):** MIYHS, 2009, 2011.

**Summary:** In 2011, 25 percent of high school students in Central PHD indicated that they thought they would be caught by the police if they smoked marijuana. This was the same as the statewide rate.

**Figure 42. Perceived risk among high school students in Central PHD of being caught by police for smoking marijuana: 2009, 2011**



Source: MIYHS

## **Mental Health, Suicide and Co-occurring Disorders**

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The relationship between substance use and mental health has been well documented. There are great efforts underway at the Substance Abuse Mental Health Services Administration (SAMHSA) and throughout Maine to better integrate mental health promotion and substance abuse prevention. At the individual level, it is important to know if one exists because the symptoms of each can affect the other; that is, a person who is depressed may abuse alcohol in an effort to feel better. At the community level, it is important to understand how the prevalence of one interacts with the other so that prevention and intervention efforts can better address the needs of both. The data indicators included below represent the first attempt to collect multiple mental health indicators that can be routinely monitored in relation to substance abuse in hopes that this will lead to better prevention and intervention.

About one-quarter of adults in Central PHD report having ever been diagnosed with depression or anxiety and almost one in four high school students felt sad or hopeless every day for two weeks in 2011; just over one in ten high school students considered suicide. The proportion of individuals from Central PHD admitted for substance abuse treatment who also have a mental health diagnosis has increased significantly since 2007.



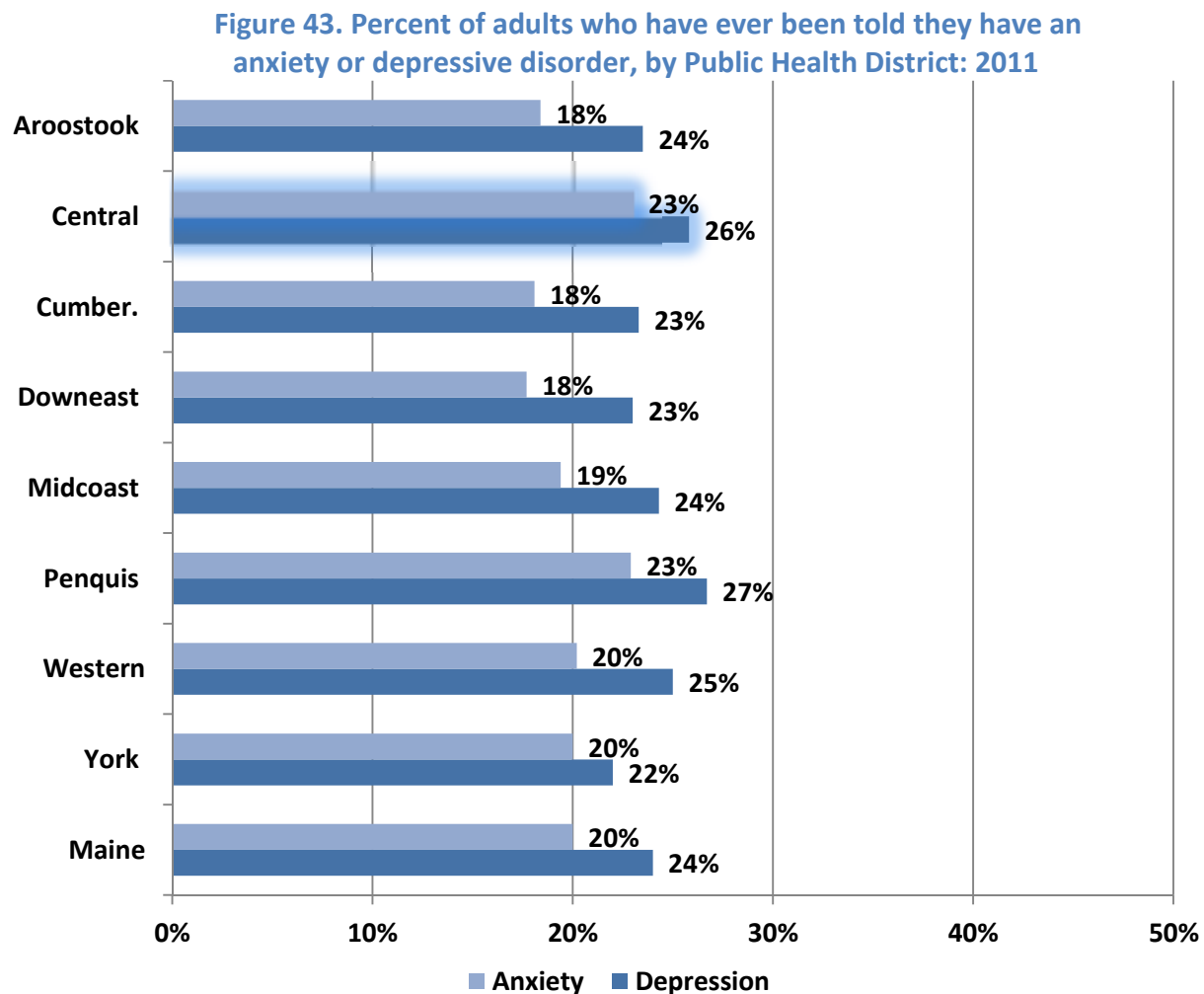
## Depression and Anxiety

**Indicator Description: DIAGNOSIS OF ANXIETY AND DEPRESSION AMONG ADULTS.** This indicator examines the percentage of Maine residents age 18 and older who have ever been told by a doctor that they have a depressive or anxiety disorder.

**Why Indicator is Important:** The link between mental health and substance abuse is well documented. Experiencing anxiety or depression is associated with higher rates of substance abuse.

**Data Source(s):** BRFSS, 2011.

**Summary:** In 2011, 23 percent of adults in Central PHD had been told they have an anxiety disorder and 26 percent had been told they have a depressive disorder. These rates were higher than those found at the statewide level (20% and 24% respectively).



Source: BRFSS

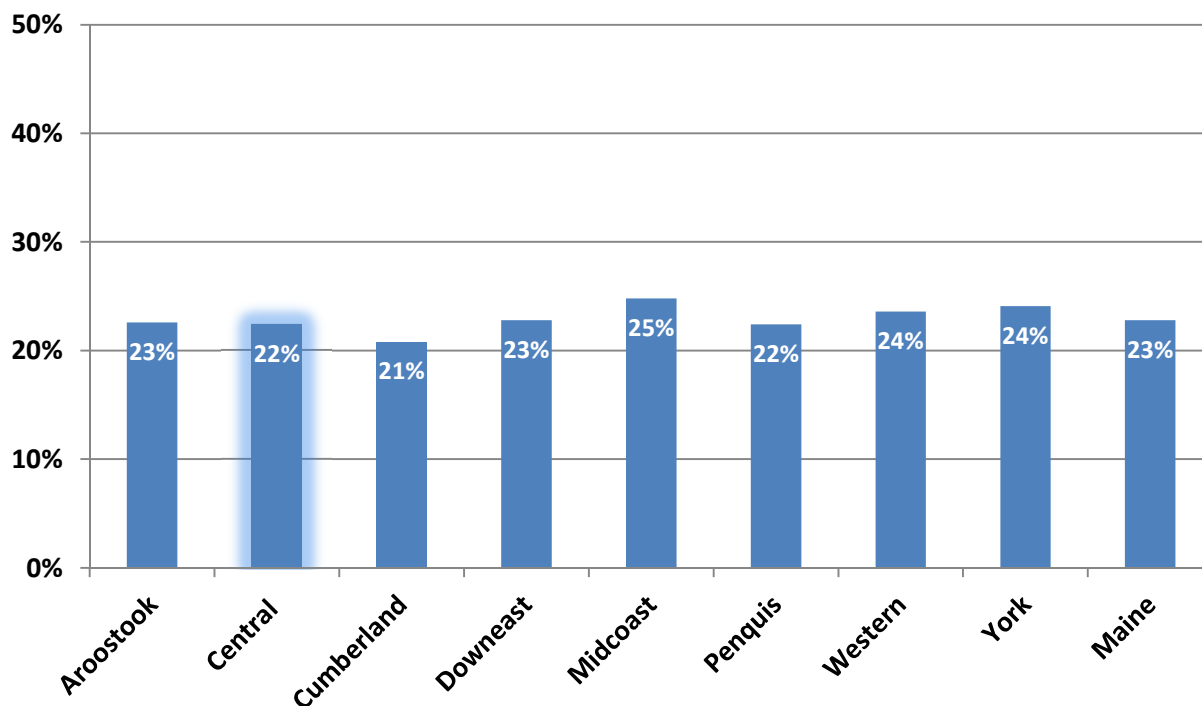
**Indicator Description: DEPRESSION AMONG YOUTH.** This indicator measures the percentage of high school students reporting they felt sad or hopeless almost every day for two weeks in a row during the past year.

**Why Indicator is Important:** Experiencing depression in the past year is associated with higher rates of substance abuse. Among youth, depression is also associated with problems with relationships and academic achievement.

**Data Source(s):** MIYHS, 2011.

**Summary:** In 2011, 22 percent of high school students in Central PHD indicated that they felt sad or hopeless every day for two weeks or more in a row during the past year. This was slightly higher rate than was reported by Maine high school students statewide (23%).

**Figure 44. Felt sad or hopeless almost every day for two weeks or more in a row during the past year, by Public Health District: 2011**



Source: MIYHS

## Suicide and Suicidal Ideation

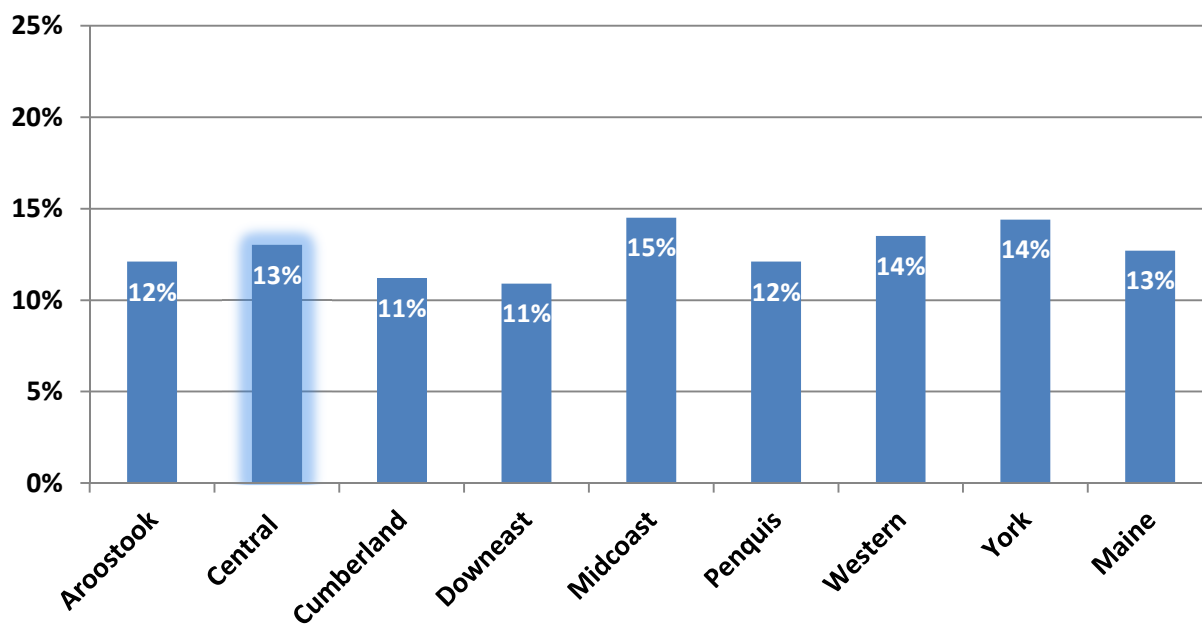
**Indicator Description: SUICIDAL IDEATION AMONG YOUTH.** This measure examines the percentage of high school students who reported that they seriously considered attempting suicide during the past year.

**Why Indicator is Important:** Suicide is the most tragic consequence of major depressive disorders. Abuse of alcohol or other drugs may increase emotional problems leading to suicidal ideation and suicidal behavior.

**Data Source(s):** MIYHS, 2011.

**Summary:** In 2011, the percentage of high school students who considered suicide during the past year was the same in Central PHD as in the state overall (13%).

**Figure 45. Percent of high school students who considered suicide during the past year, by Public Health District: 2011**



Source: MIYHS

## Mental Health and Substance Abuse Co-Occurrence

### Indicator Description: CO-OCCURRING MENTAL HEALTH AND SUBSTANCE ABUSE

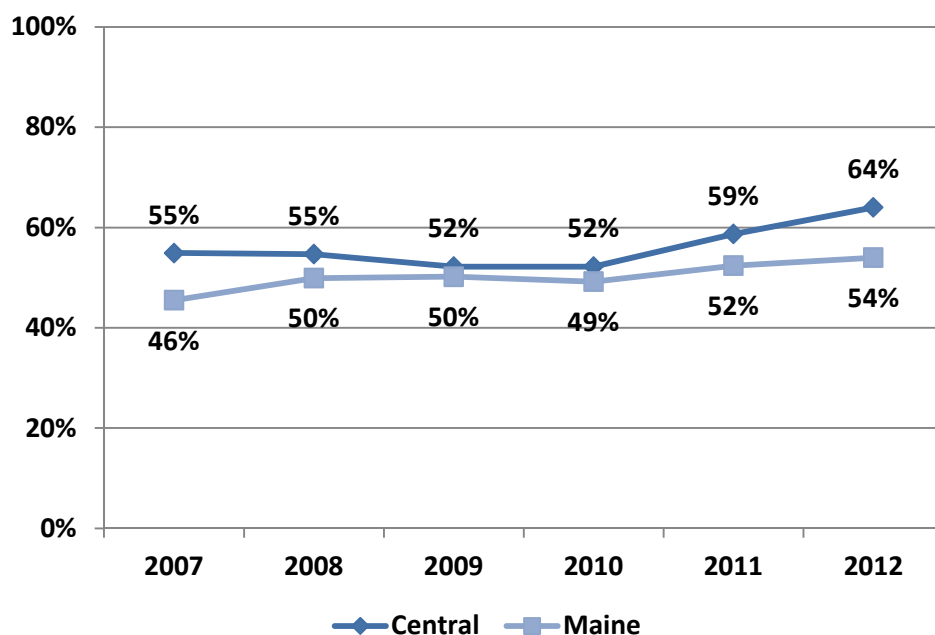
**TREATMENT.** This indicator reflects the proportion of treatment admissions for substance abuse where the individual also has a mental health diagnosis.

**Why Indicator is Important:** The link between mental health and substance abuse is well documented. In terms of treatment, it is important to know if one exists because the symptoms of each can affect the other.

**Data Source(s):** TDS, 2007-2012.

**Summary:** From 2007 through 2012, Central PHD has consistently reported a higher percentage of individuals admitted for substance abuse treatment and who also have a mental health diagnosis compared to the state. This rate increased significantly over this timeframe in Central PHD, from 55 percent in 2007 to 64 percent in 2012.

**Figure 46. Percent of individuals admitted for substance abuse treatment that also had a mental health diagnosis, by Public Health District: 2007-2012**



Source: TDS



## Treatment Admissions for Substance Abuse

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Substance abuse treatment admissions are an indicator of how many people *receive treatment* for a substance abuse problem. These admissions can be voluntary, but they can also be court-ordered. Treatment admission data should not be used as an indicator of the magnitude of the problems related to substance abuse. Rather, treatment should be seen as a major consequence stemming from substance use and one that requires many resources.

The overall number of clients admitted to treatment has been declining since 2007, from 14,843 to 11,688 in 2012. Mainers continued to seek out treatment for abuse involving a wide array of substances besides alcohol; in 2012 there were 4,135 admissions for alcohol as the primary substance. This was followed by synthetic opioids (3,838) and marijuana (1,024).

In 2012, just over one third of primary treatment admissions in Central PHD were for opiates and one-third were for alcohol; opioid-related primary treatment admissions have risen steadily. This is a similar pattern that is occurring across the state. Central PHD had a notably higher proportion of primary admissions related to synthetic opioids than the state. Among public health districts, Central had the third highest rate of synthetic opioid-related primary admissions per 10,000 residents as well as the third highest rate of heroin/morphine-related primary admissions per 10,000 residents.



## Treatment Admissions

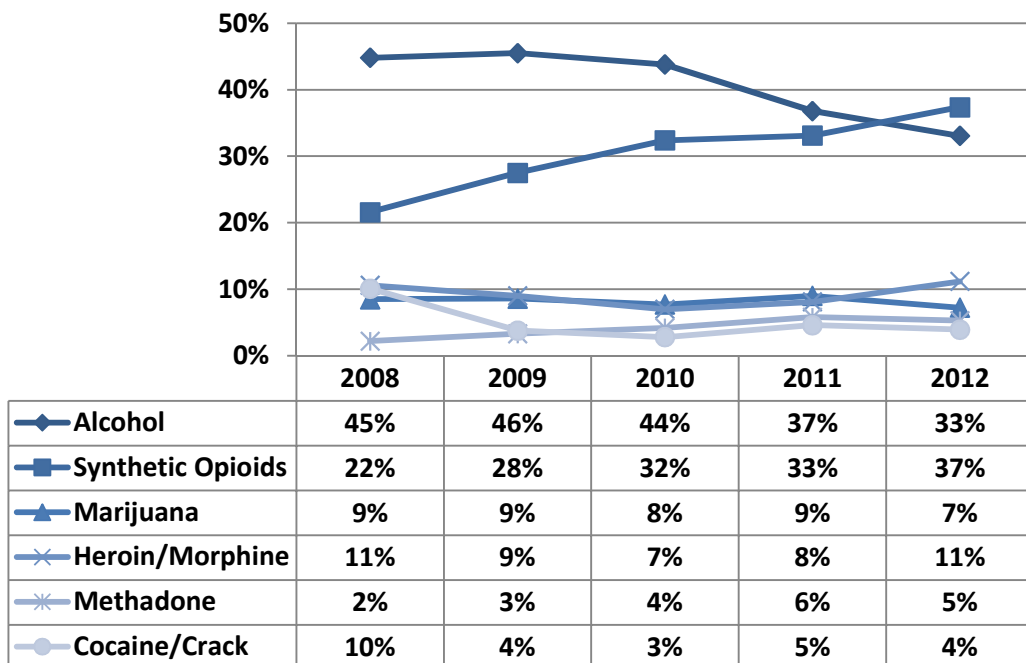
**Indicator Description: PRIMARY TREATMENT ADMISSIONS.** This measure reflects substance abuse treatment admissions. A “primary” substance is identified during the treatment admissions process based on use patterns (e.g., frequency, duration, quantity) and the risk(s) posed to the individual. The analysis excludes admissions for shelter/detoxification services.

**Why Indicator is Important:** The number of substance abuse treatment admissions is bound by both the need and the capacity for treatment. Treatment admission data are not a good indicator of substance use, abuse or dependence, but do provide an indication of service usage and the impact of substance use on the behavioral healthcare system.

**Data Source(s):** TDS, 2008-2012.

**Summary:** In 2012, 37 percent of all primary treatment admissions in Central PHD were related to opioids<sup>6</sup>, followed by alcohol (33%) and heroin/morphine (9%). In 2012, for the first time, primary treatment admissions related to opioids surpassed those related to alcohol. From 2008 to 2012 the proportion of primary admission due to opioids in Central PHD increased by 15 percentage points whereas alcohol decreased by 12 points.

**Figure 47. Primary drug admissions in Central PHD, by drug type: 2008-2012**

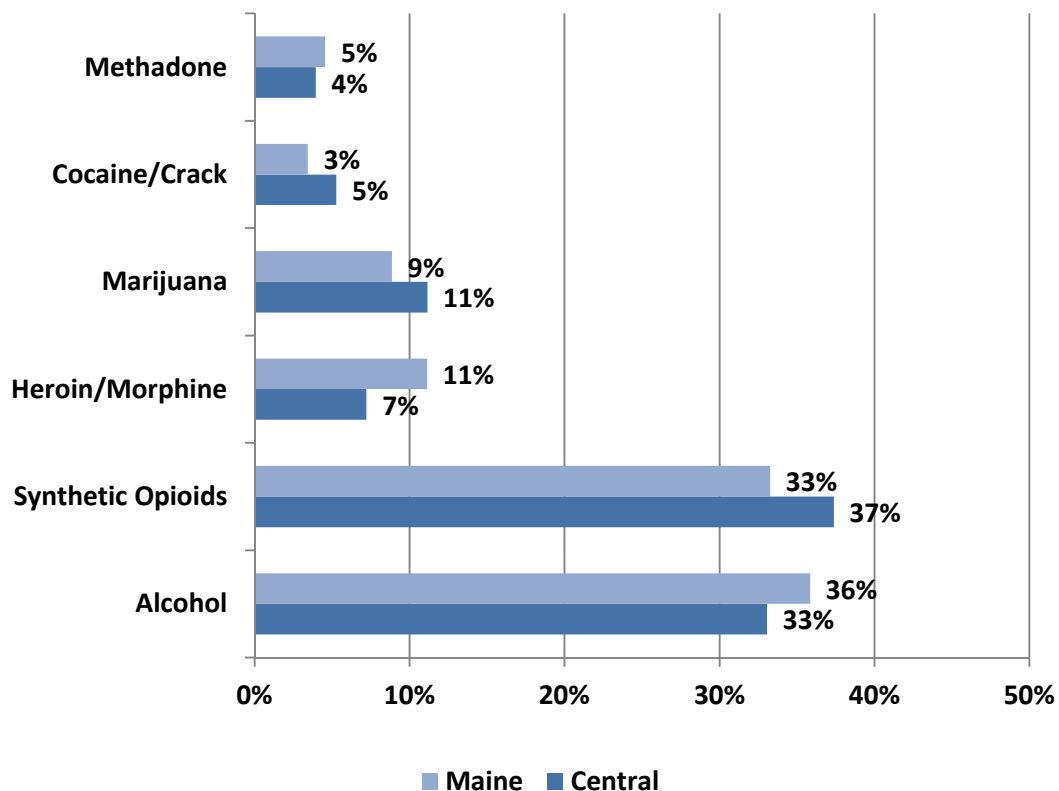


Source: TDS

<sup>6</sup> “Synthetic opioids” excludes methadone and buprenorphine.

**Summary:** In 2012, the proportion of primary treatment admissions for alcohol in Central PHD was lower than the statewide average (33% compared to 36%), while the rate for synthetic opioids was four percentage points higher than the state (37% compared to 33%). At 11 percent, Central PHD had a higher percentage of primary admissions related to marijuana compared to the primary treatment admissions statewide (9%).

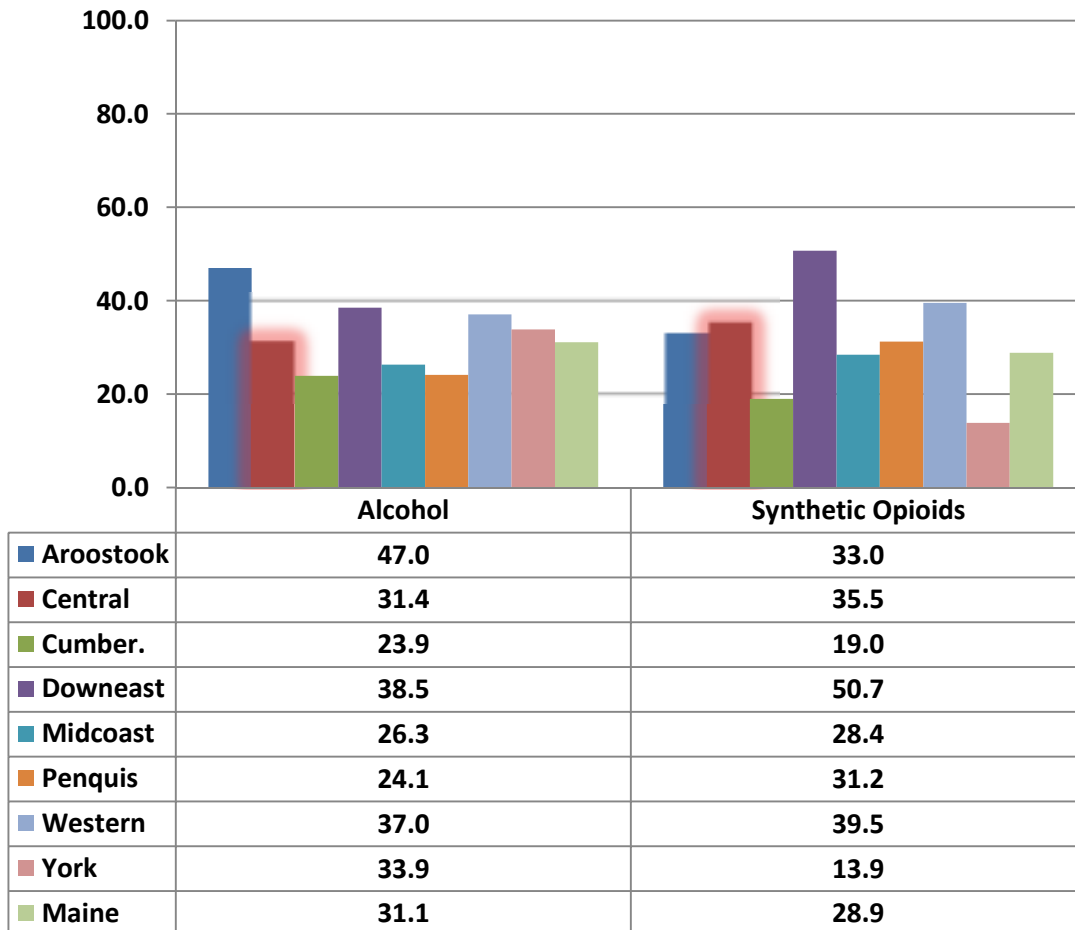
**Figure 48. Primary drug admissions in Central PHD, by drug type: 2012**



Source: TDS

**Summary:** In 2012, Central PHD had the fourth lowest rate among public health districts of primary treatment admissions due to alcohol (31.4 admissions per 10,000 residents) and the third highest rate of primary admissions due to synthetic opioids (35.5 admissions per 10,000 residents).

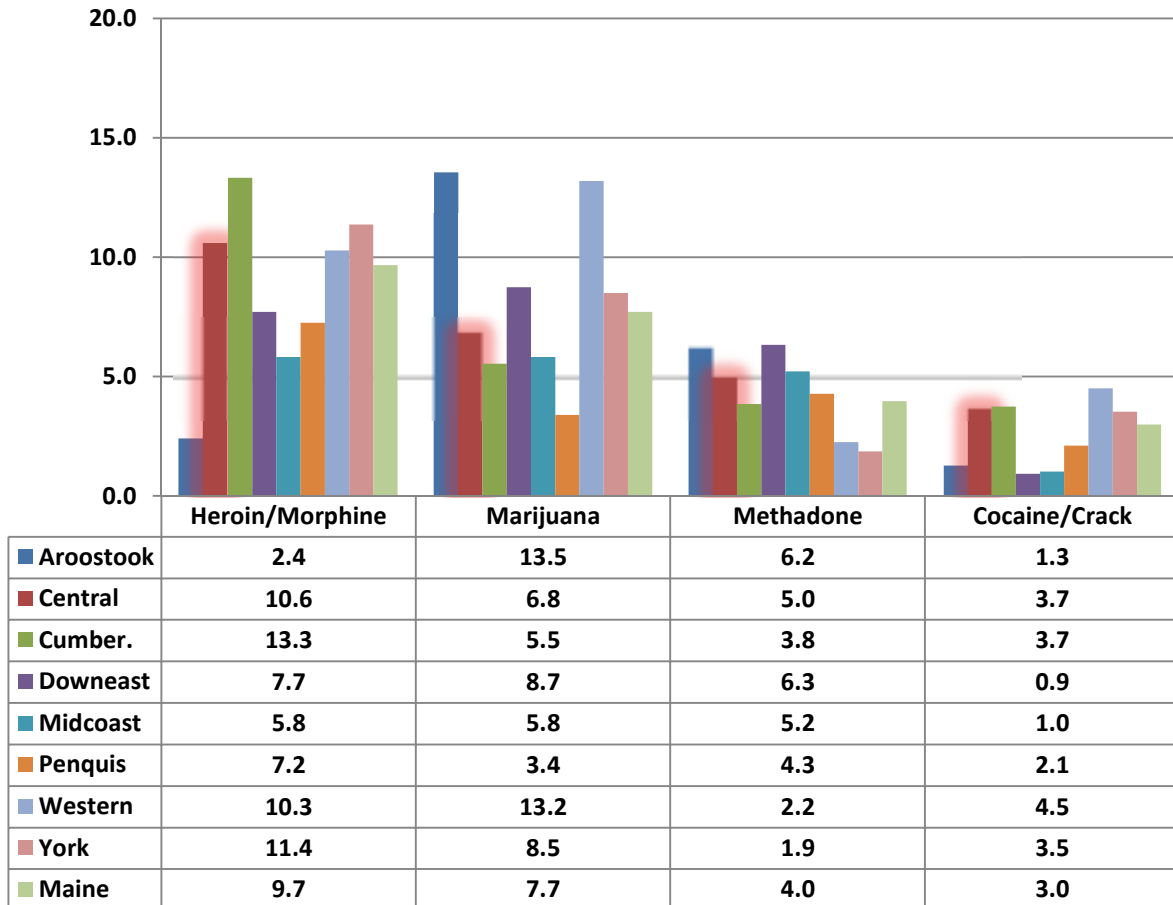
**Figure 49. Primary drug admissions per 10,000 residents, by Public Health District and drug type: 2012**



Source: TDS

**Summary:** In 2012, Central PHD had the third highest rate among public health districts of primary admissions due to heroin/morphine (10.6 admissions per 10,000), the fourth lowest rate of primary admissions due to marijuana (6.8 admissions per 10,000 residents), the fourth highest rate of primary admissions due to methadone (5 admissions per 10,000 residents), and the second highest rate of primary admissions due to cocaine/crack (3.7 admissions per 10,000 residents).

**Figure 50. Primary drug admissions per 10,000 residents, by Public Health District and drug type: 2012**



Source: TDS

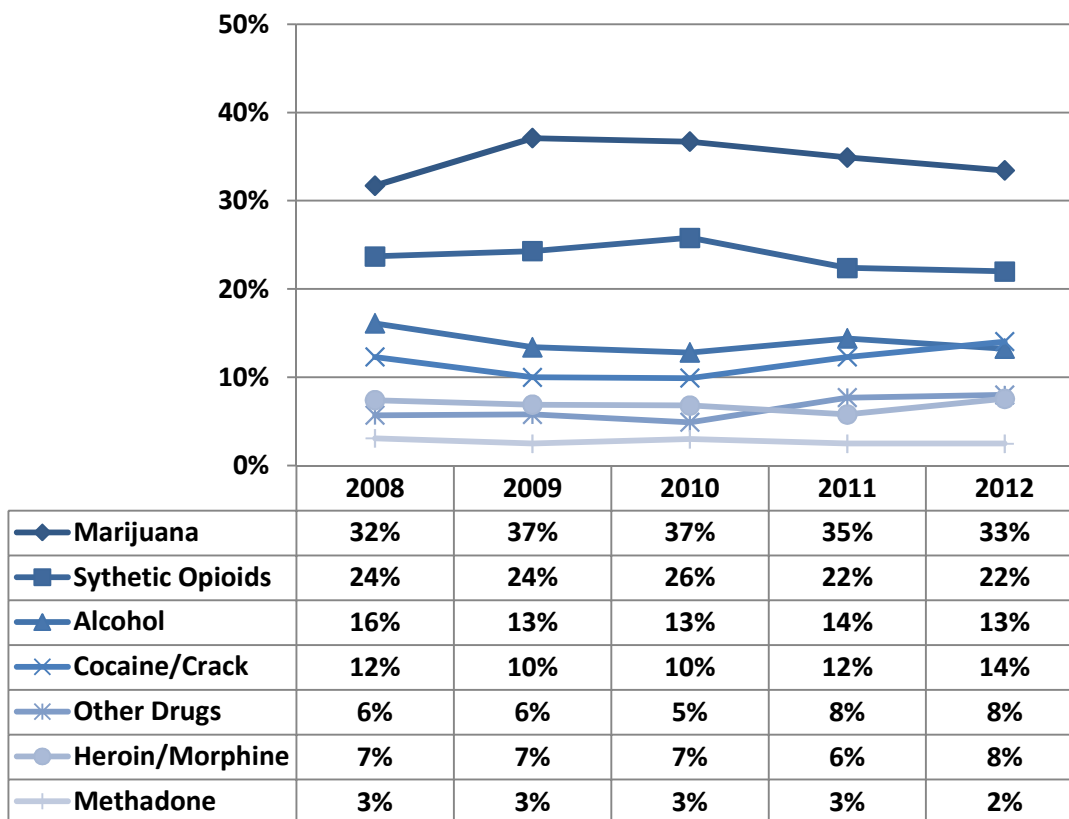
**Indicator Description: SECONDARY TREATMENT ADMISSIONS.** This measure reflects substance abuse treatment admissions. A “secondary” substance is identified during the admissions process as one used by the individual and for which treatment may be received, but it is not the primary substance for which treatment was sought. The analysis excludes admissions for shelter/detoxification services.

**Why Indicator is Important:** The number of substance abuse treatment admissions is bound by both the need and the capacity for treatment. Treatment admission data are not a good indicator of substance use, abuse or dependence but provide an indication of service usage and the impact of substance use on the behavioral healthcare system.

**Data Source(s):** TDS, 2008-2012.

**Summary:** In 2012, 33 percent of secondary treatment admissions in Central PHD were for marijuana, followed by synthetic opioids (22%), cocaine/crack (14%), and alcohol (13%). These rates have remained relatively stable since 2008, however the proportion of secondary admissions due to cocaine/crack has been increasing gradually in recent years.

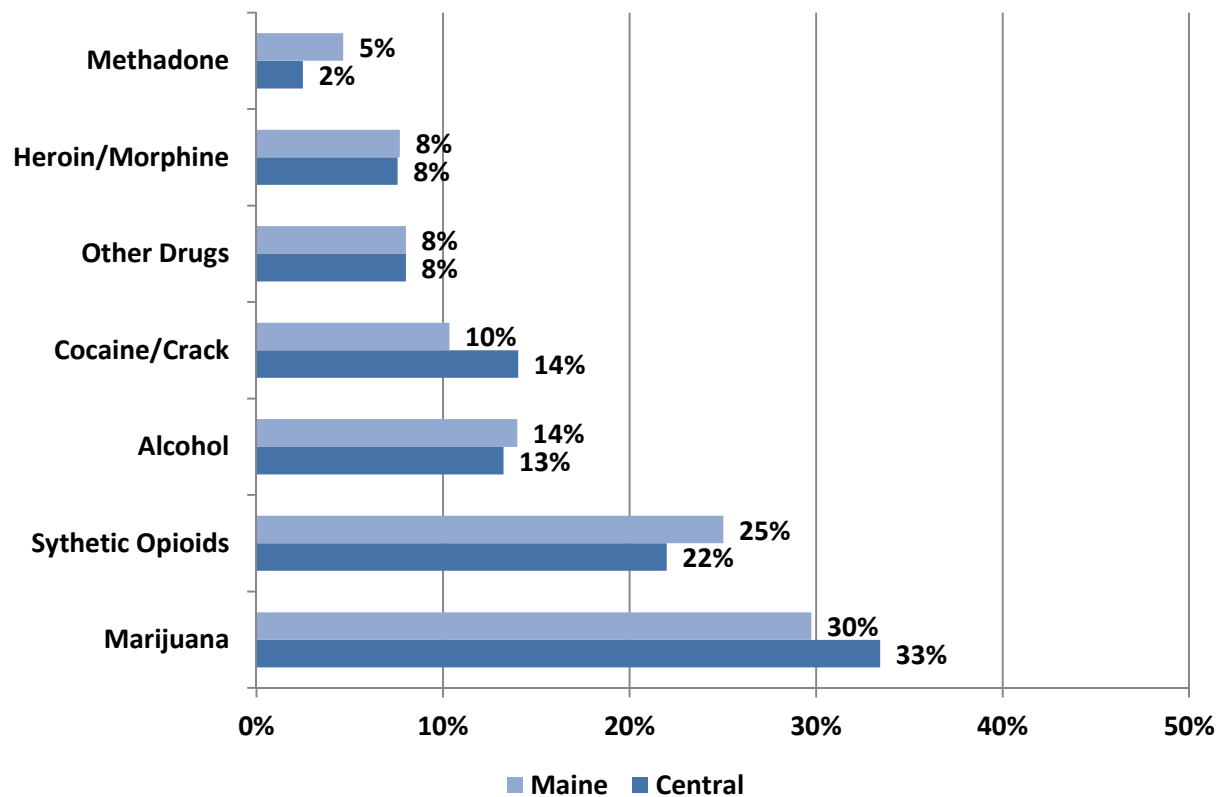
**Figure 51. Secondary drug admissions in Central PHD, by drug type: 2008-2012**



Source: TDS

**Summary:** In 2012, Central PHD had a higher percentage of secondary treatment admissions related to marijuana (33%) and cocaine/crack (14%) than the statewide average (30% and 10% respectively). Conversely, it had lower proportions of secondary treatment admissions related to synthetic opioids (22%) and alcohol (13%) than state (25% and 13%).

**Figure 52. Secondary drug admissions in Central PHD, by drug type: 2012**



Source: TDS



## Appendix: Data Sources

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This report includes data that was gathered from a number of data sources. A detailed description of each source is provided below, consisting of information about the data included in each source, and retrieval or contact information. The report includes data that were available through May 2013.

There are multiple purposes for this report. One is to provide a snapshot of the most recent data regarding substance abuse, while another is to examine trends over time. Therefore, each indicator may have multiple sources of data that are included. While each indicator provides a unique and important perspective on drug use in Maine, none should individually be interpreted as providing a full picture of drug trends in Maine. In particular, the percentages and figures from one data source do not always align with the data and percentages from a similar source. Older data are often included in order to examine an indicator among a specific population or to find trends over time. When discussing rates of prevalence, however, the user should rely upon the most recent data source available.

### Description of Data Sources

Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is a national survey administered on an ongoing basis by the National Centers for Disease Control and Prevention (CDC) to adults in all 50 states and several districts and territories. The instrument collects data on adult risk behaviors, including alcohol abuse. BRFSS defines heavy drinking as adult men having more than two drinks per day and adult women having more than one drink per day, and binge drinking as males having five or more drinks on one occasion and females having four or more drinks on one occasion. The most recent data available are from 2011. **Due to methodological changes in weighting and sampling, 2011 BRFSS data cannot be trended with previous BRFSS years.** For this reason, we have only included snapshots of 2011 BRFSS data for this year's SEOW report. Both state and national data are available. Contact: Kim E. Haggan, Maine BRFSS Acting Coordinator; [kim.e.haggan@maine.gov](mailto:kim.e.haggan@maine.gov); (207) 287-5459.

Maine Department of Public Safety (DPS), Uniform Crime Reports (UCR). UCR data include drug and alcohol arrests. Drug arrests include sale and manufacturing as well as possession of illegal substances. Liquor arrests include all liquor law violations. OUI arrests are arrests for operating a motor vehicle under the influence of a controlled substance. DPS data are now available from 2011. Arrest data may reflect differences in resources or focus of law enforcement efforts, so may not be directly comparable from year to year.

Retrieval: [http://www.maine.gov/dps/cim/crime\\_in\\_maine/cim.htm](http://www.maine.gov/dps/cim/crime_in_maine/cim.htm)

Maine Department of Public Safety (DPS), Liquor Licensing and Compliance. DPS issues and renews licenses for the manufacture, importation, storage, transportation and sale of all liquor and administers those laws relating to licensing and the collection of taxes on malt liquor and wine. DPS maintains a list of all active licenses that can be accessed online.

Retrieval: [http://www.maine.gov/dps/liqr/active\\_licenses.htm](http://www.maine.gov/dps/liqr/active_licenses.htm)

Maine Department of Public Safety (DPS), Bureau of Highway Safety (BHS), Maine Department of Transportation (MDOT). The Bureau of Highway Safety is responsible for tracking all fatalities that occur on Maine's highways and reporting this information through the Fatal Analysis Reporting System (FARS). The data represented provides information on highway crashes and fatalities. Much of this information is gathered from our FARS system, which records data on fatal crashes in Maine for input into a larger national record-keeping system of statistical data. FARS data is also used by BHS and the Maine State Police to analyze enforcement priorities and schedules. Impaired driving is one of the most serious traffic risks facing the nation, killing thousands every year. Contact: Duane Brunell, Safety Performance Analysis Manager; [duane.brunell@maine.gov](mailto:duane.brunell@maine.gov); (207) 624-3278.

Maine Drug Enforcement Agency (MDEA). The MDEA, through its eight regional multi-jurisdictional task forces, is the lead state agency in confronting drug trafficking crime. This indicator differs from the Uniform Crime Report drug-related arrest data in that it only tracks MDEA efforts and does not encompass all activity within Maine law enforcement agencies. The data included in this report represents those arrested for a drug offense but does not indicate what other drug(s) may have been seized. For example, a person may be arrested for the sale of cocaine but also be in possession of oxycodone and marijuana. It is important to note that arrests and multi-jurisdictional drug enforcement are resource-dependent; such funds fluctuate from year to year, and must be reallocated to combat highest priority threats. Contact: Roy E. McKinney, Director; [roy.e.mckinney@maine.gov](mailto:roy.e.mckinney@maine.gov); (207) 626-3852.

Maine Emergency Medical Services (EMS). Maine EMS is a bureau within the Maine Department of Public Safety (DPS) and is responsible for the coordination and integration of all state activities concerning Emergency Medical Services and the overall planning, evaluation, coordination, facilitation and regulation of EMS systems. EMS collects data statewide from the 272 licensed ambulance and non-transporting services. It is mandated that services submit an electronic patient care report to Maine EMS within one business day of patient contact. Data are compiled upon request. Contact: Jon Powers, Maine Emergency Medical Services; [jon.powers@maine.gov](mailto:jon.powers@maine.gov); (207) 626-3860.

Maine Integrated Youth Health Survey (MIYHS). The MIYHS is a statewide survey administered biennially through a collaborative partnership by the Maine Office of Substance Abuse (OSA) the Maine Center for Disease Control and Prevention and the Maine department of Education to students in grades 5 through 12. The survey collects information on student substance use, risk factors related to substance use, as well as consequences, perceptions and social risk factors related to substances, and collects information on many other health factors. As of the date of this report, the most recent data available are from 2011. Due to changes in the survey administration and structure, the new survey data cannot be trended with the Maine Youth Drug and Alcohol Survey (MYDAUS). Contact: Stephen Corral, Substance Abuse Program Specialist, Office of Substance Abuse, [stephen.corral@maine.gov](mailto:stephen.corral@maine.gov); (207) 287-2964.

Maine Health Data Organization (MHDO). MHDO data includes all inpatient admissions to all hospitals in Maine for calendar years 2010 and 2011. Data categories created by the authors include alcohol, opioids, illegal drugs, and pharmaceuticals. All drug categories include intoxication, abuse, dependence, and poisoning cases related to the drug. The opiate category includes methadone, heroin, and opiates. The illegal drug category includes crack/cocaine, cannabis, and hallucinogens. The pharmaceuticals category includes all other non-opioid medications (including stimulants and depressants). Contact: Maine Health Data Organization (MHDO), [lisa.parker@maine.gov](mailto:lisa.parker@maine.gov); (207) 287-3225.

Maine Office of the Chief Medical Examiner. The Maine Office of the Chief Medical Examiner maintains records of all deaths associated with drug overdose. Drug categories include methadone, cocaine, benzodiazepines, oxycodone and heroin/morphine. The death data are compiled on an annual basis and must be finalized prior to release and so are not available to track changes that may occur over shorter time frames. Contact: Dr. Marcella Sorg, Director, Rural Drug & Alcohol Research Program, Margaret Chase Smith Policy Center, University of Maine; [marcella\\_sorg@umit.maine.edu](mailto:marcella_sorg@umit.maine.edu); (207) 581-2596.

National Survey on Substance Use and Health (NSDUH). The NSDUH is a national survey administered annually by the Substance Abuse and Mental Health Services Administration (SAMHSA) to youth grades 6 through 12 and adults ages 18 and up. The instrument collects information on substance use and health at the national, regional and state levels. The advantage of NSDUH is that it allows comparisons to be made across the lifespan (that is, ages 12 and up). However, NSDUH is not as current as other data sources; as of this report, data at the state level are available from 2009-2010. Older data are included for trending and comparative purposes. NSDUH defines Illicit Drugs as marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or any prescription-type psychotherapeutic used non-medically; Binge Alcohol Use as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least one day in the past 30 days; Dependence or abuse based on definitions found in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV); and Serious Mental Illness (SMI) as a diagnosable mental, behavioral, or emotional disorder that met the criteria found in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and resulted in functional impairment that substantially interfered with or limited one or more major life activities. Retrieval: <https://nsduhweb.rti.org/>

Northern New England Poison Center (NNEPC). The Northern New England Poison Center provides services to Maine, New Hampshire, and Vermont. A poisoning case represents a single individual's contact with a potentially toxic substance. Intentional poisoning includes those related to substance abuse, suicide and misuse. Data include the number of confirmed cases where exposures are judged to be substance abuse-related (i.e., an individual's attempt to get high). NNEPC collects detailed data on specific substances involved in poisonings, including the categories of stimulants/street drugs, alcohol, opioids, asthma/cold and cough,

benzodiazepines, antidepressants, and pharmaceuticals, as well as other substances. The category of stimulants/street drugs includes marijuana and other cannabis, amphetamine and amphetamine-like substances, cocaine (salt and crack), amphetamine/dextroamphetamine, caffeine tablets/capsules, ecstasy, methamphetamine, GHB, and other/unknown stimulants/street drugs. The category alcohol includes alcohol-containing products such as mouthwash. The opioid category includes Oxycodone, Hydrocodone, buprenorphine, methadone, tramadol, morphine, propoxyphene, codeine, hydromorphone, stomach opioids, Meperidine (Demerol), heroin, Fentanyl, and other/unknown opioids. The asthma/cold and cough category includes eye, ear, nose, and throat medications. Data available from the poison center are reported on a continual daily basis and are included through December 2012. These data are only reflective of cases in which the Poison Center was contacted. Contact: Karen Simone, Director, Northern New England Poison Center; [simonk@mmc.org](mailto:simonk@mmc.org); (207) 662-7221.

Prescription Monitoring Program (PMP). PMP maintains a database of all transactions for class C-II through C-IV drugs dispensed in the state of Maine. Drug categories used in this report include narcotics, tranquilizers, stimulants, and other prescriptions. Other prescriptions include those drugs that are not classified as narcotics, tranquilizers or stimulants, including products such as endocrine and metabolic drugs, analgesics and anesthetics, gastrointestinal agents, and nutritional products. The counts included in this report represent the quantity dispensed through prescriptions filled between 2006 and 2012. Contact: John Lipovsky, PMP Coordinator, Substance Abuse and Mental Health Services; [john.lipovsky@maine.gov](mailto:john.lipovsky@maine.gov); (207) 287-3363.

Treatment Data System (TDS). TDS is a statewide database that includes information about clients admitted to treatment in OSA-funded facilities through December 2012. Analyses in this report are based on clients' reported primary, secondary and tertiary drug(s) of choice as well as other demographic and background information that is collected at intake. Drug categories included in this report are alcohol, marijuana, cocaine, heroin, synthetic opiates, methadone/buprenorphine and benzodiazepines. Contact: Stacey Chandler, Substance Abuse and Mental Health Services; [stacey.chandler@maine.gov](mailto:stacey.chandler@maine.gov); (207) 287-6337.

U.S. Census Bureau. The U.S. Census provides summary profiles showing frequently requested data items from various Census Bureau programs. Profiles are available for all states and counties, and for cities and towns with more than 25,000 people. Data are updated no less than annually. Retrieval for Maine census data: <http://quickfacts.census.gov/qfd/states/23000.html>